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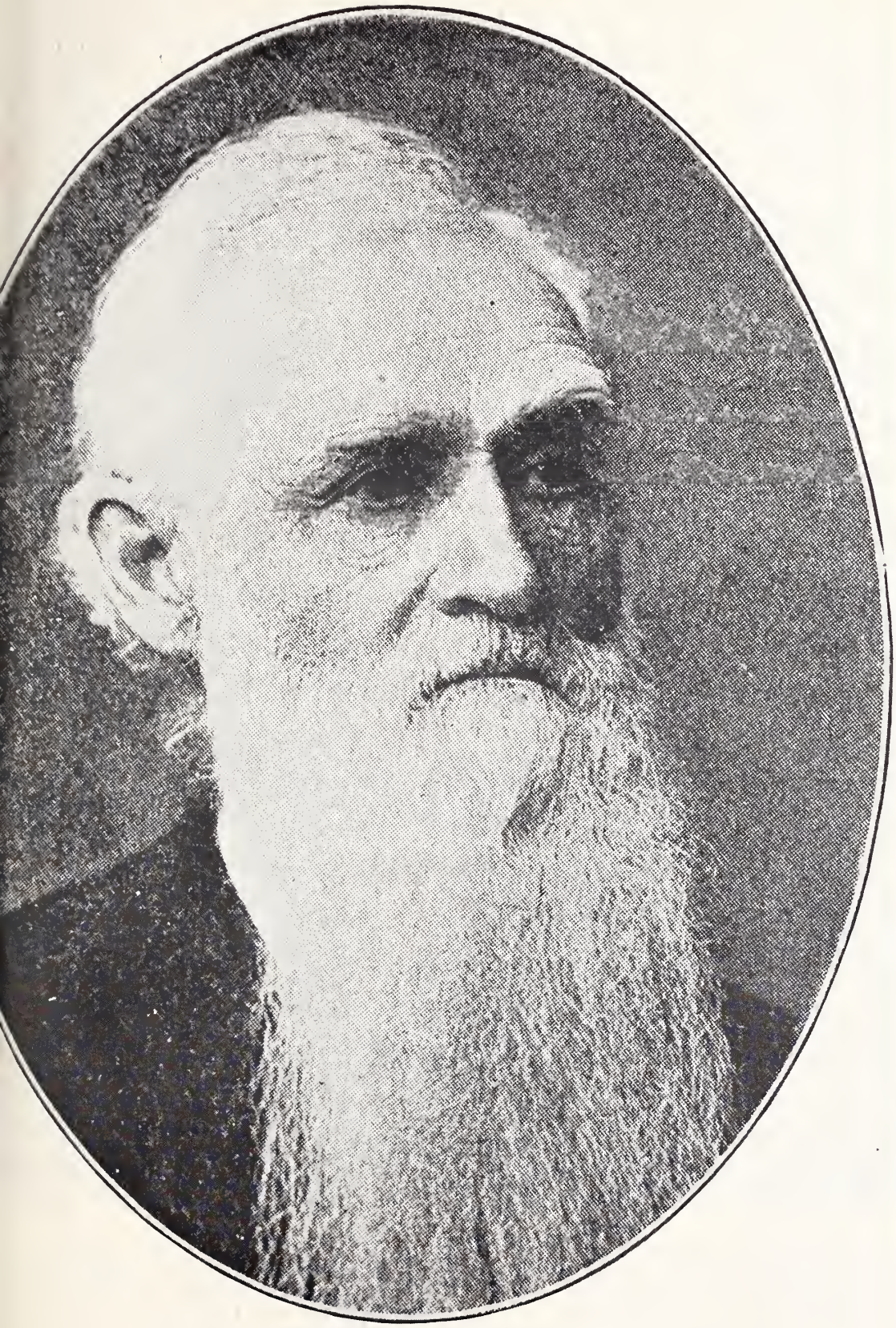
Journal of the Medical Society of New Jersey



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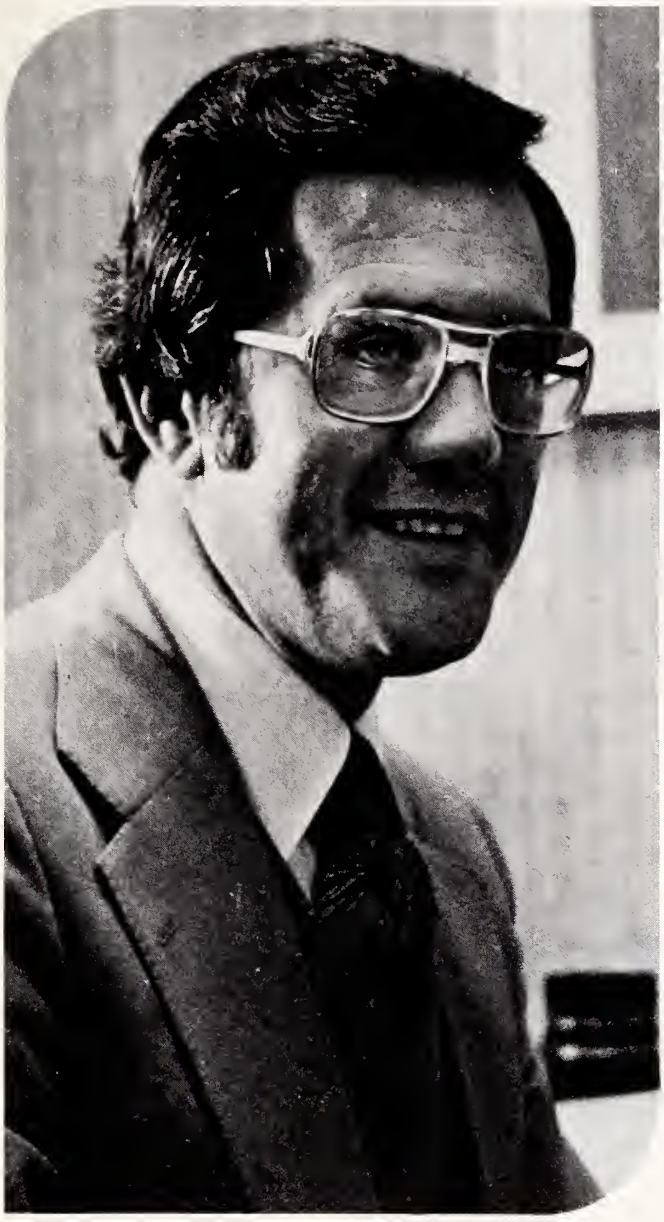

Introducing our Administrator

Anthony G. DiCarlo, was born in New York City, where he attended the High School of Commerce. Air Force service followed, and while stationed at Mitchell Field on Long Island, he began commuting at night to The College of the City of New York. Night courses continued following his discharge, and after eight years he earned his accounting degree and subsequently was certified as a Public Accountant.

His first assignment was as Assistant Controller of Lenox Hill Hospital. Next was Controller of Southampton Hospital on Long Island. In 1970 he returned to Manhattan to assume the controllership of the French Polyclinic Hospital and in 1975, when New Jersey Rehabilitation Hospital opened, he joined as Controller. Two years later he was appointed Assistant Administrator, and in 1978 he was appointed Administrator.

Mr. DiCarlo is a member of the American College of Hospital Administrators, the Hospital Financial Management Association, and the American Institute of Certified Public Accountants.

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The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles; clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

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Accident Facts. Chicago, Illinois, National Safety Council, 1974.

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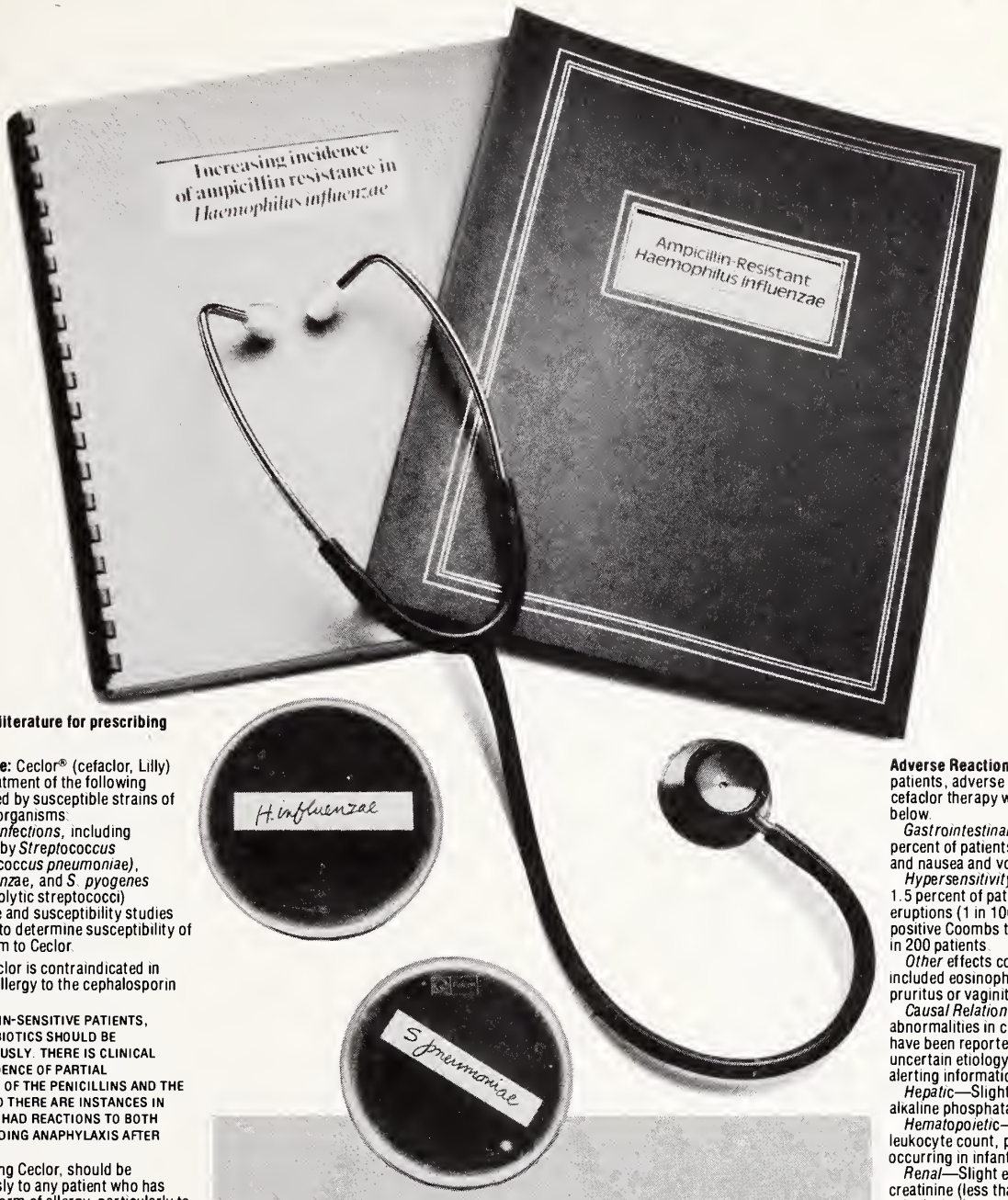
An added complication... in the treatment of bacterial bronchitis*



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Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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cefaclor
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Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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RULE 4:21 PANEL HEARINGS

"The physician-panelist is not there to do the defendant-physician a favor, but to ajudicate whether there was or was not a deviation from medical standards to which the defendant-physician should have adhered. If so, was this partially or completely responsible for the condition which the plaintiff sustained?" So stated the Honorable Arthur J. Blake in his talk to physicians during MSNJ's 1980 Annual Meeting.

A panel consisting of the Honorable Arthur J. Blake, Assignment Judge of Essex County and Chairman of the Supreme Court's Committee on Relations with the Medical Profession, James S. Todd, M.D., then Chairman, Board of Trustees, MSNJ and Chairman, Board of Directors, Medical Inter-Insurance Exchange of New Jersey (MIIENJ), and Bernard H. Genest, Director of Claims of MIIENJ, discussed the effectiveness of panel hearings as established by *Rule 4:21* at a session on May 10th devoted to that matter.

According to Judge Blake, when panel proceedings and provisions are mandated by the legislature, controversies can develop regarding the constitutionality of the panel. In New Jersey the panels were established by a ruling of the New Jersey Supreme Court. This allows the court to recommend and adjust rules which can enhance the effectiveness of the panels and promote a fair and just method of ajudication for all parties, thus lessening the chance of a challenge on grounds of constitutionality. As an example of judicial flexibility with regard to panel proceedings and rulings, Judge Blake reported upon recommendations being proposed by the Supreme Court's Committee on Relations with the Medical Profession which will have a direct bearing on physician involvement on the panels. Presently, a medical panelist may be called to trial as an expert witness in the event of a unanimous panel finding. It has been recommended that this rule be amended to prohibit the calling of a medical panelist to testify at trial.

Judge Blake views the working relationship of this panel Committee as a positive factor toward the elimination of distrust between the medical and legal professions.

Further evidence of judicial flexibility is the recommendation of the Supreme Court's Committee on Relations with the Medical Profession to add two medical physicians and two osteopathic physicians as standing members of this important Committee, enhancing the Committee's goal of improving relationships among the three professions, (judicial, legal, and medical).

Statistical data presented by Judge Blake for the time period of January 1979 through October 31, 1979, revealed that a total of 165 cases had been scheduled, of which 112 hearings were concluded, 13 cases were pending, and 40 cases were disposed of prior to hearing. Of the 112 hearings, 91 decisions were unanimous and twelve were non-unanimous. Of the unanimous decisions, fifty percent (50%) are still pending before the courts; seventy-five percent (75%) of the non-unanimous decisions are pending before the courts. Eighty-two and a half percent (82.5%) of the cases were decided in favor of the defendant; seventeen and one-half percent (17.5%) were decided in favor of the plaintiff. *It is most interesting to note that in non-unanimous panel hearing decisions, the physician-panelist favored the plaintiff in seventy-five percent (75%) of the cases.*

Judge Blake informed the physician audience that the average trial time for a malpractice case is about six days. This does not include the time spent on interviews, depositions, or interrogatories. Contrastingly, panel hearing average time is three and a half hours. Only three of the 112 hearings lasted more than one day; nine lasted approximately one day.

In conclusion, Judge Blake, a strong advocate of the panel hearing process, acknowledged that the panel program is still in its infancy, but is demonstrating effectiveness as a mechanism for meeting the challenge of resolving professional liability cases. "This program is on solid ground and moving forward and will succeed essentially if you (the physician) will cooperate," said Judge Blake.

"The purpose of *Rule 4:21* is to discourage baseless activities, encourage settlement of claims based on reasonable medical probability, monitor efficiently these cases through the court, and assist in early disposition of medical malpractice activities. If that isn't a banner we can fly under, I have never heard one," stated Dr. Todd in his opening remarks.

Dr. Todd reiterated the optimism expressed by Judge Blake and encouraged physicians to volunteer as panelists. "If the panel hearing process fails, let it not be because of the disregard of physicians and the Medical Society."

"There are attorneys throughout the state who totally opposed *Rule 4:21,*" claimed Dr. Todd. "I must say at the moment, with one notable exception to the plaintiff's bar, most of those detracting from the system are defense attorneys."

"*Rule 4:21* is not going to solve all our problems," continued Dr. Todd, "and it is not perfect as it is, but it has demonstrated that two professions with a mutual problem can meet on common ground and discuss and reach amicable settlements."

In his concluding remarks, Dr. Todd suggested a need for a mechanism whereby a case would be expedited through the courts or settled within a stipulated period of time, once a panel decision has been made. This would prevent cases which have received a panel decision from languishing while attorneys decide on their next course of action.

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*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

"Actual medical malpractice is not a legal problem, it is a medical problem. It is the presence of a claim or suit alleging medical malpractice that turns the problem from a medical one to a legal one. This is the focus of our problem," claimed Mr. Genest.

MIIENJ insures sixty percent (60%) of the physicians in New Jersey. The company's in-house peer review program determines the course of events of alleged claims presented to the company. Should the peer review determine an alleged claim to be indefensible, settlement negotiations are begun with the consent of the insured physicians. If the peer review determines an alleged claim is defensible, the company so informs the plaintiff attorney who then has the option to pursue or drop the claim. Consequently, the only cases presented by MIIENJ to the *Rule 4:21* panel are those which are felt to be defensible.

MIIENJ has been in operation for three years and only recently has begun to have cases heard by the *Rule 4:21* panels. Of the ten (10) cases which had a panel hearing, nine were found defensible at the panel hearing and these same nine cases previously were found defensible at MIIENJ peer review. The one case found indefensible by the panel was initiated prior to the establishment of the MIIENJ peer review program.

According to Mr. Genest, two of the cases which were found defensible by the panel proceeded to trial and were again found in favor of the physician. In four (4) of the cases the plaintiff's attorneys have not, as yet, decided to drop these cases. Three (3) cases were voluntarily dismissed by the parties, but only after a considerable lapse of time from the panel's decision. In one case, the voluntary dismissal came after six months, in another, after seven months, and in the third, only after the trial had been called. Mr. Genest felt the length of time from a panel decision to voluntary dismissal was too long and advocated that the courts study this problem for a possible solution.

Remarks from the audience indicated a favorable, optimistic approach to *Rule 4:21* and its purpose. This Department will continue to work with the Administrative Office of the Courts and report on the progress of *Rule 4:21*.

Editor's Note: One of the reforms to emerge from the malpractice crisis of the mid-seventies was the establishment of pre-trial screening panels. In seventeen states the panel mechanism has been challenged on constitutional grounds. Thus far, the state supreme courts have upheld the constitutionality of the panels in nine states. Only in Florida, Illinois, Missouri, and North Dakota have the panels been held to be unconstitutional. Four states are awaiting prehearings by their state supreme courts. The April 28 issue of *Medical Economics* contains a comprehensive summary of malpractice reforms worthy of physician attention.

NEW JERSEY LAW JOURNAL (5/15/80)

"N.Y.C. Malpractice Fees Hit $2 Million Mark—It may cost the City of New York $2 million a year to defend its municipally operated hospitals against malpractice suits, if the state Financial Control Board approves a proposed agreement between the city and a law firm.

"The proposed contract between the Health and Hospitals Corporation, which operates the city's 17 hospitals, and Bower & Gardner, a New York City law firm, 60 percent of the practice of which is in hospital, medical school and pharmaceutical company defense, will generate that much in fees, it has been estimated.

"Under the contract, the firm would assume defense of 1,500 cases presently pending against the city and would assist in designing a continuing risk management and prevention program."

DID YOU KNOW . . . . . .

. . . The New York State Supreme Court awarded $7.125 million in damages to a ten-year-old girl who suffered irreversible brain damage during a 1973 tonsillectomy. A six-member jury awarded the child $6 million for "pain, suffering, disability, and injury" and $750,000 for "future medical and institutional care." The parents were awarded $375,000 for nursery services they provided her. *(New York Times* 3/23/80)

. . . A Tennessee physician received an $11,500 award from a jury against a plaintiff attorney for his malicious prosecution and abuse of a process suit. More than eighty countersuits have been filed by physicians nationwide and at least three physicians have received awards. *(American Medical News* 3/28/80)

. . . Economic worth of services in the home has become an important issue in cases of wrongful injury or death. B.F. Kiber, Ph.D., Chairman of the Department of Economics at the University of South Carolina, applies economic theory to measuring the value of services provided in the home by husbands and wives. Using a table which considers time and value of activities, a 27-year-old housewife contributes about $14,250 annually in household production. *(N.J. Law Journal* 4/3/80).

. . . "Re: Lawyers' v. Doctors' Fees

"Editor, *New Jersey Law Journal:*

"Please print this paragraph in the *Law Journal:*

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New Jersey Law Journal 4/30/80

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EDITORIALS

The 1980 House of Delegates

The business of the Medical Society of New Jersey is the democratic responsibility of the House of Delegates. Items are brought before the House via Reference Committees, which hold open and closed sessions to receive and consider particulars which are of interest to, and indeed may influence, the lives of physicians and their patients. After careful consideration and debate, a majority opinion of the Reference Committee is concentrated into a report and ultimately delivered to the House of Delegates for deliberation and action. Such reports, or parts thereof, may be voted up or down, sent to the Board of Trustees, referred back to Committee, tabled, or in some way acted upon.

Items also come before the House from the Board of Trustees, from officers of the Society, or from the floor, i.e., from the members of the House itself. The House elects Officers, Judicial Councilors, AMA delegates and members of the Board of Trustees, Administrative Councils and Standing Committees.

The extent of the democracy of this institution depends on the extent of the active input from its membership, from county component medical societies, and the seriousness, fairness, and adherence to parliamentary procedure of the deliberate body. One can report that the House of Delegates at the 214th Annual Meeting of the Medical Society of New Jersey—under the watchful eye of representatives of the news media, the medical students of New Jersey schools and observers from the medical societies of neighboring states, New York, Connecticut, Pennsylvania, and Maryland, and the American Medical Association—did its duty.

Some of the actions of the 1980 House of Delegates included the following:

• **Attendance at Board Meetings**—An item came before the House from the Board of Trustees itself based on a "demonstrated degree of skepticism toward the Board of Trustees" by the House of Delegates. It resolved "that the House of Delegates instruct each county society to have the chairman, or his designee, of its delegation attend each meeting of the Board of Trustees in order to participate in the decision-making process of the Board." This resolution was approved.

• **National Health Insurance**—The Medical Society of New Jersey went on record, by adopting a resolution introduced by the Hudson County Medical Society, "that any modifications of the health insurance system embody the following principles:

"1. All health insurance policies sold in the United States be required to provide adequate benefits conforming at least to minimum standards as defined by the AMA.

"2. A simple system of uniform benefits be provided, for persons who cannot afford to purchase their own health insurance, by federal government payment of premiums to insurers, in part or in whole as appropriate.

"3. A nationwide program be provided by the private insurance industry to make available catastrophic insurance coverage to counter the tragic economic impact of a catastrophic illness on an individual or family.

"4. Appropriate cost-sharing by the patient or the employer (through deductibles and coinsurance) be a part of basic and catastrophic coverage.

"5. Freedom of choice by physicians and patients be preserved.

"6. Programs developed in accordance with these principles be administered at state level through use of non-governmental insurance mechanisms."

The House also resolved that the Medical Society of New Jersey continue to oppose any federally-controlled or federally-administered national health insurance. This resolution will be forwarded to the American Medical Association.

• **Chiropractic**—The House of Delegates adopted a resolution affirming the following statement of the AMA regarding chiropractic:

"The American Medical Association knows of no scientific evidence to support spinal manipulation and adjustment as appropriate treatment for human ailments such as essential hypertension, heart disease, stroke, cancer, diabetes, and infections. Accordingly, the Association will continue to warn the public of the hazards to health in entrusting the diagnosis and treatment of such conditions to practitioners who rely upon the theory that all disease is caused by misalignment of spinal vertebrae and can be cured by manual manipulation and adjustment of the spine."

• **Physicians' Assistants**—The House adopted a resolution introduced by the Union County Medical Society on the subject of Physician Assistants. The resolution stated "that the New Jersey Delegation to the AMA lead a movement to remove endorsement of physicians' assistants by the AMA and by each state medical Society."

• **Mandatory AMA Membership**—This was a big one, which was introduced by the Bergen County Medical Society and was approved by a vote of 142 to 83, "that the Medical Society of New Jersey adopt a unified membership policy and that membership in the American Medical Association be mandatory for all Medical Society of New Jersey members."

• **New Jersey Board of Medical Examiners**—In the light of major areas of disagreement between the State Board and MSNJ and the need for closer understanding and cooperation between the two bodies, the following resolution was introduced by the Mercer County Medical Society and adopted by the House: "that the President of the New Jersey State Board of Medical Examiners or his designate be invited to deliver a report of the year's activities of the State Board

of Medical Examiners before the physicians of the Medical Society of New Jersey at its Annual Meeting; such report shall cover areas of mutual dialogue and interest during the past year."

• **Proposed Revision of the Code of Medical Ethics of the AMA**—The Principles of Medical Ethics have been the subject of debate and deliberation for more than a year by an Ad Hoc Committee of the AMA under the chairmanship of James S. Todd, immediate past chairman of the Board of the Medical Society of New Jersey. This Committee has proposed certain revisions of the existing Code of Medical Ethics of the AMA based in part on the following philosophy: "While primarily for the benefit and protection of patients, such (ethical) principles clearly must embrace the relationship of physicians to their colleagues and to contemporary society. No one should expect any Principles of Medical Ethics to stand unchanged forever, but by responding in a consistent fashion to a rapidly expanding and changing society, the American Medical Association can be worthy of the moment and the future."

A resolution on this subject was introduced from the floor and approved. It stated:

"RESOLVED, that the House of Delegates of the Medical Society of New Jersey commend the Ad Hoc Committee on Principles of Medical Ethics for a job well done; and be it further

"RESOLVED, that the Medical Society of New Jersey support the report of the Ad Hoc Committee with the contained proposed revisions of the 'Principles of Medical Ethics,' while at the same time requesting the Ad Hoc Committee to consider carefully all suggestions from the grass-root level in preparing its next submission to the AMA's House of Delegates."

• **Charter Change re Representation in the House of Delegates**—The issue of representation of specialty societies, medical students, and conceivably others in the House of Delegates was brought before the House by the Board of Trustees. In order to modify such representation, it requires an amendment of the corporate charter of MSNJ, as well as an amendment of the Constitution and Bylaws. Since the legislative charter takes precedence, the Board asked the House for authorization to petition the New Jersey Legislature to recognize the right of MSNJ to define (and thus change) the representatives in its House of Delegates. This was approved and will be requested.

• **New Jersey Foundation for Health Care Evaluation**—The House approved an assessment for the New Jersey Foundation for Health Care Evaluation recommended by the Finance and Budget Committee.

In its May 1980 Annual Report, the Foundation indicated its projected activities for fiscal year 1980-1981 as follows:

1. To continue to provide administrative services to the Professional Standards Review Council.
2. To explore the establishment of a voluntary organization of New Jersey IPA physicians.
3. To develop a management program aimed at improving medical care services to the aged.
4. To investigate the creation of a Quality Assurance Program for Medical Care within New Jersey's correctional institutions.
5. To establish a Data Consortium in collaboration with PSROs in New Jersey.
6. To evaluate and report on the performance of HMOs within the state of New Jersey and nationally.
7. To explore the feasibility of establishing a Coalition—between the medical community and private interest groups—to study the problems related to medical care delivery in New Jersey.
8. To investigate the establishment of an external quality review program for all HMOs in New Jersey.
9. To strengthen existing relationships between the medical community and federal, state, and local planning agencies.

• **Undergraduate Clinical Training of Foreign Medical Graduates**—A delegate from the Bergen County Medical Society pointed out the inequities to the residents and taxpayers of New Jersey who obtain medical education in foreign medical schools and have been denied the opportunity "to qualify (to practice in our state) through hospital work and clinical work in New Jersey" by the State Board of Higher Education.

The following resolutions were presented and approved:

"That the Medical Society of New Jersey publicly state its objections to the recent abrupt denial of undergraduate clinical training to New Jersey students attending foreign medical schools and that it is the opinion of the Medical Society of New Jersey that this decision should be reversed and residents of New Jersey should be allowed to do fifth, sixth, seventh, and eighth semester work in approved New Jersey hospitals.

"That the Medical Society of New Jersey publicly should declare its feelings in this matter to the New Jersey State Legislators and to the Board of Higher Education and the State Board of Medical Examiners."

"That the New Jersey Board of Higher Education, on application by foreign medical schools, make a determination as to which schools should be approved to send students to New Jersey hospitals. The hospitals being used for such training should be approved by the New Jersey Board of Higher Education."

• **Diagnosis Related Groups (DRG) Concept**—The Hudson County Medical Society introduced resolutions concerning DRGs, which they characterize as a "disparate method of overcoming some of the obstacles being encountered" in health care financing. They pointed out that DRGs "received conditional approval" from the Medical Society of New Jersey as an "experimental program," that there are admitted major problems with DRGs that defy resolution, and that "full implementation (of the DRG program) may prove disastrous."

The resolutions which were adopted stated:

"That the Medical Society of New Jersey is opposed to the DRG concept," and "that the Medical Society of New Jersey advocates a moratorium on further implementation of the DRG methodology until such time as the 'experimental' involvement of the present 26 participating hospitals can be evaluated."

• **Expose Cost of Governmental Regulations**—The Hudson County Medical Society is very concerned about the burden of governmental regulations on health care costs. A resolution which they introduced was adopted and states:

"That the House of Delegates reaffirm its instruction to the Council on Public Relations to give top priority to exposing to the public the high cost and adverse effect of governmental regulations on the cost of health care and, in particular, on the voluntary cost-containment effort."

• **Federal Subsidy of HMOs**—The Hudson County Medical

Society introduced a resolution, which was adopted, and which states "That the Medical Society of New Jersey petition the government to cease and desist from subsidizing HMOs and restore fair competition."

Although the resolution was adopted as written, it was pointed out from the floor that the government (not defined, i.e., federal and/or state or other) does not "subsidize" HMOs, but loans money at interest, albeit the rates charged are lower than usual bank charges. It also was noted that the resolution does not differentiate between the closed-panel type HMO and the IPA type of HMO.

• **Environmental Health**—The House indicated its concern in the area of environmental health by adopting a resolution which called for the Medical Society of New Jersey "to take a very active role in calling for cessation of sludge dumping." A second resolution, which concerned full disclosure of the investigative findings at the chemical dump explosion in Elizabeth, was adopted. The primary concern was "that physicians may effectively detect and treat immediately medical problems attributable to this environmental danger."

The business of the 214th Annual Meeting of the Medical Society of New Jersey was of interest to all physicians. It is a pity that those practitioners who live and work in New Jersey and do not belong to this Society are unaware of the depth and breadth of the energies, debates, and emotions of the participants who struggled with mainstream medical and health issues which concern all physicians. Perhaps each member of the Society can share this editorial, which barely touched the surface of some of the actions of the Medical Society of New Jersey, and the more detailed publication, *Transactions 1980 House of Delegates* (vol. 77, no. 8, issued July 16, 1980) with a New Jersey physician who is not presently a member of the Society. Knowledge and participation are much better than ignorance and complaints about medical and health issues. A.K.

JMSNJ Is Indexed

Some authors have been concerned that articles published in *The Journal* may be lost to the medical community outside of New Jersey. With confidence we say, never fear!

As indicated by Dr. Clifford A. Bachrach, Editor, *Index Medicus* (see letters this issue, page 549). *The Journal* of the Medical Society of New Jersey is and has been indexed regularly for many years. The material is retrievable from MEDLARS as well.

New Jersey authors who write noteworthy material which we publish can feel certain that their work will be recognized. A.K.

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JEMPAC REPORTORIAL*

PHYSICIAN RUNS FOR CONGRESS

Scott L. Sibert, M.D., of Gloucester County, is running as Republican candidate for United States Congressman from New Jersey's First District against the incumbent James J. Florio, Democrat.

Dr. Sibert pursued his undergraduate studies at the University of Pittsburgh and received his Doctorate of Medicine from West Virginia University School of Medicine. Since 1971 Dr. Sibert has been involved in the private practice of psychiatry with offices in West Deptford, New Jersey. He resides with his wife and three children in Woodbury.

JEMPAC ACTIVITIES AT MSNJ'S 1980 ANNUAL MEETING

The importance of physician involvement and the "Do's and Don'ts" on how to communicate with your legislators were the topics of United States Congressman Harold C. Hollenbeck's presentation at the 1980 Annual JEMPAC Breakfast on May 12.

Eighty physicians and their spouses who were in attendance at the breakfast viewed a slide presentation developed by Frank Y. Watson, M.D., Chairman of JEMPAC, titled "When You're Up To Here In Alligators. . . . . ."

Later the same day JEMPAC hosted a "wine and cheese" reception for more than two hundred persons. Representatives of each of the five leading presidential candidates presented a summary of their respective candidates' platforms.

In addition to these activities Dr. Watson addressed the House of Delegates at the opening session regarding the present and future plans of JEMPAC, and there was an informational booth in the exhibition hall.

MSNJ'S POSITION ON PROPOSED NJ LEGISLATION

Information regarding MSNJ's position on various proposed legislation will be presented in each **Reportorial.** We urge you to write to the sponsors, the committee and, the individual committee members to make your views known—c/o the State House, Trenton, NJ 08625.

Assembly-561—Walter M. D. Kern, Jr. (40th District, part of Bergen) The "Nurse-Midwife Licensing Act." **ACTIVE OPPOSITION** because this legislation advocates a double standard of medical care and fosters the unlicensed practice of medicine.

Assembly-562—Walter M. D. Kern, Jr. (40th District, part of Bergen) To prohibit granting of any new license to practice midwifery under the present law. **ACTIVE OPPOSITION** because existing statute and proposed regulations fully address the needs of the patients of New Jersey.

Assembly Bills 561 and 562 have been assigned to the **Commerce, Industry and Professions Committee:**
Byron M. Baer, Chairman, David C. Schwartz, Vice-Chairman, Robert P. Hollenbeck, William E. Flynn, Arthur R. Albohn, Gerald Cardinale, Hazel Gluck

Assembly-321-Richard F. Visotcky (36th District, part of Bergen) To revise the statute of limitations concerning tort actions. **ACTIVE SUPPORT**

Assembly Bill 321, has been assigned to the **Judiciary, Law, Public Safety and Defense Committee:**
Martin A. Herman, Chairman, William J. Bate, Vice Chairman, John Paul Doyle, Eugene J. Thompson, William E. Dowd, William L. Gormley, Walter M.D. Kern, Jr.

*The *JEMPAC REPORTORIAL* will be a monthly feature designed to inform members of MSNJ of PAC activities and to report issues of mutual concern. It is hoped this will heighten physician awareness of the need for participation in the political process. This item from JEMPAC was prepared by Frank Watson, M.D., and A. Ronald Rouse, who are, respectively, Chairman of the Committee and Executive Director and Editor.

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If your practice is incorporated, JEMPAC and AMPAC voluntary political contributions should be written on a PERSONAL CHECK. Contributions are not limited to the suggested amount. Neither the AMA nor the Medical Society of New Jersey will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC Regulations, Sections 110.1, 110.2 and 110.5. (Federal regulations require this notice).

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Treatment of Status Asthmaticus Bronchial Asthma-Part III *

FREDERIC A. SCHULANER, M.D., Westfield
MICHAEL S. MATTIKOW, M.D., Wayne.

Status asthmaticus is a medical emergency requiring vigorous therapy. Arterial blood gas determinations and clinical observation are essential to delineate the severity of the attack and the progress of the patient. Every effort must be made to prevent respiratory acidosis.

Asthma is characterized by an increased response of the trachea and bronchi to various stimuli, manifested by widespread narrowing of the airways and changes in severity, either spontaneously or as the result of therapy.[1] Status asthmaticus is a medical emergency defined as a severe exacerbation of asthma initially unresponsive to usual therapy.[2] In children, this implies a failure of two to three injections of epinephrine (1:1000 given subcutaneously at 0.01 mg/kg, twenty to thirty minutes apart) to relieve the dyspnea and to reduce the wheezing. In adults the criteria are not as clear; if the patient does not respond to 0.3 to 0.5 ml of 1-1000 epinephrine followed by 0.3 ml in thirty minutes and/or intravenous aminophyllin in a dose of 5.6 mg/kg given slowly over 15 to 20 minutes, then status is present.[2]

PRECIPITANTS AND PATHOPHYSIOLOGY

The most common precipitants of status asthmaticus are listed in Table I.[3] Viral infections are more common than bacterial. Propranolol hydrochloride (Inderal®) can precipitate severe attacks. Undertreatment is a preventable cause of status asthmaticus; the problem may be too low a dose of bronchodilators or not using corticosteroids when indicated. In adults, aspirin is an important trigger of severe attacks, and sensitive patients should be taught to avoid that drug in all its guises.

The most common pathological finding in patients dying from status asthmaticus is thick tenacious plugs of mucus obstructing the bronchi of all sizes. In addition, the bronchi and bronchiolar walls are thickened with cellular infiltrates of eosinophils, plasma cells and lymphocytes. Subepithelial mast cells often are depleted in fatal status asthmaticus.[4] There is also hypertrophy of the smooth muscle layer of the bronchial wall.

The airway obstruction of an asthmatic attacks leads to premature airway closure during expiration, with subsequent alveolar hypoventilation. At the same time, there is hyperinflation, leading to increased work of breathing and dyspnea.[5] Concomitantly, there are developing abnormalities of the alveolar ventilation/capillary blood flow ratios (V/Q), with resulting hypoxemia. Initially, there is a compensatory increase in total alveolar ventilation with a subsequent decrease in the $paCO_2$. Increasing airway obstruction results in further hypoventilation which cannot be compensated with a now steadily rising $paCO_2$ and further hypoxemia. The final stage is uncompensated respiratory acidosis and respiratory failure.

STAGES AND TREATMENT OF STATUS ASTHMATICUS

In treating status asthmaticus it helps to grade the severity of the attack. By classifying wheezing into mild, moderate, or

*This is the last in a series of papers from the New Jersey Allergy Society on the modern approach to diagnosis, office management, and hospital care of the asthmatic. Correspondence may be addressed to Dr. Schulaner, 546 Westfield Ave., Westfield, NJ 07090.

"Fundamental therapy consists of oxygen, intravenous fluids, and intravenous aminophylline."

severe one will be able to treat patients more effectively, know when to ask for help, give a reasonable estimate of the length of morbidity, and assess more realistically the effects of therapy upon the course of the disease. Such a classification is found in Table II.

One approach to status asthmaticus is to divide treatment into (1) a fundamental therapy that will be given, except in unusual circumstances, to all patients admitted, and (2) those measures that may be required, depending upon the severity of the attack or complications that arise during therapy. Fundamental therapy consists of oxygen, intravenous fluids, and intravenous aminophylline. (See Table III). Anyone with asthma severe enough to be hospitalized will require all three.

Hypoxemia is universal in status asthmaticus. To prevent cellular damage and death, one must avoid the "knee" of the oxygen saturation curve, where small changes of oxygen tension will cause large changes in oxygen saturation. Keeping the oxygen tension above 80 mm. Hg will keep the patient above this dangerous area. Humidified oxygen should be administered before intravenous aminophylline or isoproterenol hydrochloride because these drugs can increase the ventilation/profusion imbalance, and further accentuate existing hypoxemia. In adults as well as children with asthma, there is no danger of suppressing the respiratory center with oxygen, as might occur in chronic obstructive lung disease.

Most patients with status asthmaticus are somewhat dehydrated because of vomiting and decreased fluid intake. Moreover, there is excessive water loss from tachypnea. The intravenous fluids should be relatively dilute, (0.2% normal saline with 5% D/W) and given at one and one-half to two and one-half times maintenance, depending upon the clinical situation. After the patient has voided, potassium is added. One of the most important functions of the intravenous fluids is to prevent the inspissation of mucus, and to aid in the elimination of the tenacious plugs that are so characteristic of status asthmaticus. There are theoretical dangers of over-hydration, as the increased microvascular hydrostatic pressure and decreased plasma osmotic pressure create a tendency toward pulmonary edema. Therefore, one must not be overzealous with intravenous fluids.

The third aspect of fundamental therapy is intravenous aminophylline. The availability of blood theophylline levels at many institutions now allows the physician to achieve therapeutic blood levels of 10 to 20 ug/ml without the fear of toxicity. In children a loading dose of 5 mg/kg of aminophylline given over 15 to 20 minutes will achieve a level of over 10 ug/ml in most, with only a few above 20 ug/ml. Increasing the loading dose to 7.5 mg/kg will increase the level in most to 15 ug/ml, but at the same time more will have levels of over 20 ug/ml.[6] The loading dose is followed by a constant infusion at 0.9 mg/kg/hr. A blood theophylline level should be obtained between twelve and twenty-four hours, and the dose readjusted according to the results. It is essential to know how much theophylline the patient has received before the bolus of intravenous aminophylline is given. If he has been on adequate doses (over 4 mg/kg every six hours for a least three days) then the therapeutic strategy must be changed. These patients already may have blood levels approaching, or in the therapeutic range; in this situation the safest course of action would be to begin with a maintenance dose and eliminate the bolus. A blood theophylline level is measured immediately and the dosage adjusted according to the results. If the patient has been on irregular doses of theophylline for two days or less, one may give fifty percent of the bolus initially. Of course each regimen must be individualized. The present recommended dose for adults (over sixteen years of age) is to begin with a loading dose of 6 mg/kg of aminophylline, followed by an infusion of 0.5 mg/kg/hr.[7] A blood level of theophylline should be obtained twelve and twenty-four hours after institution of therapy and the dose adjusted if necessary. Studies in adults who have status asthmaticus have demonstrated that there is such a marked variability in clearance, and that a maintenance dose of 0.9 mg/kg/hr may be too high for many. Table III illustrates how to readjust the maintenance dose.

Table I
Precipitants of Status Asthmaticus

1. Respiratory tract infection
2. Ineffective treatment of wheezing episodes
3. Intense exposure to an allergen or chemical irritant

There are many factors that influence the clearance of theophylline and necessitate a change in dosage. Smoking will increase the clearance in adults and in teenagers. The maintenance dose should be increased to 0.8 mg/kg/hr, while congestive heart failure, liver disease, pneumonia, very severe respiratory obstruction and the use of erythromycin would necessitate a decrease in dosage (for instance, 0.2 mg/kg/hr).[8] Blood levels should then be obtained and maintenance dose adjusted accordingly.

Many patients admitted to the hospital will respond to these three measures with alleviation of dyspnea, decreased wheezing and improvement of breath sounds. However, if there is no obvious improvement following initiation of such therapy or if the patient is initially in Stage II or beyond, additional therapy is required. (See Table IV),

The next drug to use is a sympathomimetic bronchodilator, administered by inhalation, since most patients have just had a trial of subcutaneous epinephrine. Isoproterenol and isoetharine (Bronkosol®) are the only two we presently have available that can be used with a wall nebulizer and oxygen. The treatment can be stopped as soon as relief is obtained. If this happens before the dose is completely used and the wheezing returns, then treatment can be resumed. If the patient is worse following such therapy, then it should be discontinued. In most patients IPPB has no advantage over a nebulizer with oxygen. The disadvantages of the IPPB are its cost and greater risk of pneumothorax of pneumomediastinum.

Corticosteroids are quite effective in the treatment of status asthmaticus and are not dangerous for short-term use. All patients who are truly in status require its use. Their method of action in asthma is speculative and the doses given are empirical, but corticosteroids have been found to be effective whether the patient has been on steroids previously

"Corticosteroids are quite effective in the treatment of status asthmaticus and are not dangerous for short-term use."

"Sedatives, tranquilizers, antihistamines, aerosolized enzymes, cromolyn sodium, beclomethasone and narcotics should not be used in the treatment of status asthmaticus."

or not. [9] The length of time the corticosteroids are used depends upon the patient's clinical course. A decrease in the total eosinophil count by fifty percent after institution of therapy usually indicates that an effective dose of corticosteroids has been given.[10]

Acidosis should be corrected when the pH drops below 7.2. (See Table IV). Too vigorous a correction further can alter the ventilation/profusion ratios, with an increase of hypoxemia. The pH, if corrected, should be kept between 7.30 and 7.35.

Antibiotics are not required unless one has evidence of, or strongly suspects, a bacterial infection, particularly sinusitis and/or pneumonitis. Since Hemophilus influenzae often is found, this organism should be considered in the choice of an antibiotic until cultures are completed.

Sedatives, tranquilizers, antihistamines, aerosolized enzymes, cromolyn sodium, beclomethasone and narcotics should not be used in the treatment of status asthmaticus. Physical therapy is recommended by some as a means to help eliminate mucus. However, it can be very exhausting during an acute attack; it is probably safer to wait until there is some improvement before employing that form of therapy.

EVALUATION DURING THERAPY

A critical evaluation of the patient during therapy is essential in such a dynamic process as status asthmaticus. (See Table V). Baseline data on admission should include complete blood count, urinalysis, arterial blood gases, blood chemistries, tuberculin test, appropriate cultures, and chest x-ray. Both clinical findings and laboratory data are used in evaluating the patient's progress. One carefully should evaluate the breath sounds and listen for wheezing; note the antero-posterior chest diameter and the movements of the chest. If present, sternocleidomastoid contraction and supraclavicular indrawing is related to severe airway obstruction. [11] If the patient improves as expected, the chest x-ray need not be repeated, but if wheezing persists or the patient becomes progressively worse, repeated x-rays are indicated. Arterial blood gases and pH give a sensitive assessment of the severity of asthma and the progress of the patient. A patient in Stage I who responds immediately to fundamental therapy may not need these studies repeated. The patient admitted in early Stage II or beyond, or the one who does not respond to initial therapy will need such studies. How often they are repeated depends upon the patient's response to the therapy, the severity of the attack, as well as the results of the previous studies. One should keep in mind that in Stage II, the $paCO_2$ is normal or only slightly elevated and the pH is normal or only slightly decreased. Vigorous therapy and close observation are required to keep the patient from entering Stage III.

The pulse and blood pressure have a definite relationship to the severity of asthma. Tachycardia over 130, particularly in older children and adults, is related to the degree of hypoxemia and a drop in pulse correlates well with improvement.[12] Pulsus paradoxus over 20 mm. Hg in children and 10 mm. Hg in adults is found in many cases of severe asthma. It is a helpful clinical finding because its presence always denotes severe obstruction and hypoxemia. Its absence however, does not mean that severe obstruction is not present.[14] Serial determination of flow rates can be very useful in assessing the patient's progress. One can organize the clinical and laboratory data into a flow sheet and follow the patient's course more easily.

Parenteral therapy is discontinued when there is no longer any dyspnea and breath sounds, pulse, blood pressure and blood gases are normal. There may be some residual hypoxemia and expiratory wheezes present, however. The patient then is placed on the oral medications corresponding to his parenteral therapy and, after twenty-four to forty-eight hours, if improvement is sustained, he or she can be discharged on appropriate medication and followed as an outpatient.

ASSISTED VENTILATION

Patients who do not respond to the above intensive program, but have ever-increasing respiratory distress, rising $paCO_2$, and respiratory failure need assisted ventilation. Except for the rare patient who presents in the emergency room in extremis, physicians should know beforehand who may be a candidate for such therapy and alert the appropriate personnel to such a possibility. In order to treat such a patient, a team consisting of a chest physician experienced in assisted ventilation, an anesthesiologist and a respiratory therapist is necessary. Table VI lists the criteria that are useful in diagnosing respiratory failure requiring assisted ventilation. The blood gases which are the most sensitive indicators of such an event, must be followed closely.

The object of assisted ventilation is to sustain life until the pathological processes are reversed. The general consensus today is not to do a tracheostomy, but to use an endotracheal tube while using 100 percent oxygen during the procedure, along with sedation and neuromuscular blockade. A chest x-ray is required following intubation to be certain the tube is

"The object of assisted ventilation is to sustain life until the pathological processes are reversed."

Table II
Classification of Status Asthmaticus

I. Mild	II. Moderate	III. Severe
maderate dyspnea	marked dyspnea	exhaustian
use af accessary muscles of respiratian	tracheal retractian	fixed chest
inspiratary and expiratary wheezes	increased wheezing	decreased wheezing
decreased breath saunds	paar breath sounds	absent breath saunds
decreased $paCO_2$	narmal/slight increase $paCO_2$	marked increase $paCO_2$
decreased pO_2	further decrease pO_2	extreme decrease pO_2
increased pH	narmal/slight decrease pH	marked decrease pH

Table III
Fundamental Therapy

1. Oxygen – keep pO_2 above 80 mm. Hg.
2. Intravenaus Fluids –
   1.5 – 2.5 x maintenance requirements
   0.2 N saline in 5% D/W
   After vaiding, add 20 meq. K/liter fluid
3. Intravenaus Aminophylline –
   Use peripheral vein with balus given during
   15 – 20 minutes while manitaring patient
   Children – Loading Dase: 5 – 7.5 mg/Kg
   Maintenance Dase: 0.9 mg/Kg/hr.
   Adults – (aver 16 years)
   Laading Dase: 6 mg/Kg
   Maintenance Dase: 0.5 mg/Kg/hr.

Obtain a bload theophylline level and adjust the infusian

$$\text{rate} \times \frac{\text{desired blaad level}}{\text{actual blaad level}}$$

Table IV
Additional Treatment

1. Sympathamimetics
   Isoproterenol 1-200 ar Isoetharine nebulizatian with oxygen at 4 – 6 L/min.
   Dilute with 1.5 – 2.5 ml. af narmal saline
   Given far 15 – 20 min. q4h prn
   Discantinue if distress increases follawing use.
2. Carticasteraids

Hydracortisane (Salu Cortef®) (I.V.)	4 mg/kg laading dose, fallowed by 3 mg/kg/24 haurs ar 200 mg. laading dose followed by 100 mg. q 6 hr.
Prednisane (aral)	1 mg/lb/24 hr (2 mg/kg) – tap dase 80 mg/day. Taper and stap whe chest is clear 48 haurs. (Exception – patients an long-term steraids)
3. Sodium bicarbonate	Use when pH falls belaw 7.2 $NaHCO_3$ meq. = 1.5 x bady weight (Kg) or $NaHCO_3$ meq. = Base excess x 0.3 weight (Kg)

4. Antibiotics – Use anly when indicated

properly placed in the mid-trachea and there is no pneumothorax that can occur following this procedure. A volume preset respirator is preferred. The patient must be coordinated with the respirator and this requires a neuromuscular blockade. It is important that the $paCO_2$ does not drop too rapidly (over 5 mm/Hg/hr) because of the danger of arrythmias, hypotension or seizures. Sedation for amnesia and analgesia also is used. Of course, steroids, sympathomimetics and aminophylline are continued and the patient is closely monitored. When the $paCO_2$ is less than 50 mm/Hg with normal oxygen tension, and there is clearing of atelectasis or hyperinflation on the x-ray, along with improving breath sounds, then attempts can be made carefully to discontinue ventilation.

Table V
Evaluation of Therapy

1. Physical Examination
   - wheezing
   - breath sounds
   - use of accessory muscles of respiration
   - cerebral function
2. Arterial Blood Gases
   - most important assessment of severe asthma
3. Chest X-Ray
   - repeat when indicated
4. Vital Signs (P,R,BP)
   - pulse over 130 related to degree of hypoxemia
   - pulsus paradoxus (drop in blood pressure during inspiration) increase of +20 mmHg found in severe asthma
5. Flow Rates
   - FEV_1, FEF 25 to 75 helpful in following degree of progress

Table VI
Criteria for Assisted Ventilation
(one or more may be present)

1. $paCO_2$ over 65 mm Hg
2. pO_2 less than 60 mmHG in 100% oxygen
3. Rising $paCO_2$ (+5 mmHG/hr) in exhausted patient
4. Fixed chest with absent breath sounds and wheezing
5. Decreased level of consciousness and response to pain

COMPLICATIONS

One must be alert to the possibility of complications from such therapy, including nasal necrosis, acute otitis media, tension pneumothorax, nosocomial infections, respiratory alkalosis and sub-glottic stenosis.

In several centers in the past few years intravenous isoproterenol hydrochloride has been used in children when the usual treatment fails and before starting mechanical ventilation. It has been successful in many patients, but does require experienced personnel; it is not without risk. It should not be used at this time in the community hospital setting.

Table VII lists the complications of status asthmaticus that may have precipitated the attack originally, or may be a cause of deterioration or unresponsiveness during therapy. Pneumonia occasionally can be due to contamination of equipment used to treat patients; in those situations one must suspect pseudomonas infection. Atelectasis, especially of the right middle lobe is not uncommon. It usually clears with bronchodilator therapy, however, persistent atelectasis may require bronchoscopy.

Pneumothorax can be secondary to the bronchial asthma itself or to IPPB therapy. Tension pneumothorax is rare; when present it requires decompression immediately. If there is bilateral pneumothorax, with increasing respiratory distress, the patient must be placed on assisted ventilation.

Pneumomediastinum and subcutaneous emphysema, although dramatic should not compromise the asthmatic patient, except under unusual circumstances.

Mucus plugging and impaction is what we are trying to prevent by our therapy. Small amounts of saline (2 to 10 ml) are used during mechanical ventilation to remove the tenacious globs of mucus. If unsuccessful and the patient continues to fail, then pulmonary lavage must be considered. Here, between 35 and 50 ml. of warm saline are put into one lung by a special catheter, while the other is being ventilated. This is a hazardous procedure and only should be done by an experienced surgical team.

Table VII
Complications of Status Asthmaticus

1. Pneumonia
2. Atelectasis
3. Pneumothorax
4. Pneumomediastinum and subcutaneous emphysema
5. Mucous plugs

SUMMARY

Status asthmaticus is severe wheezing and dyspnea not responding to emergency outpatient therapy. Classifying episodes into mild, moderate or severe can be helpful in managing the condition. Fundamental treatment consists of oxygen, intravenous fluids and intravenous aminophylline with blood levels of theophylline to determine the proper dosage. Sympathomimetics, bronchodilators, corticosteroids, bicarbonate and antibiotics are used when indicated. Critical evalution of the patient's progress is essential, using both clinical findings and laboratory data, particularly arterial blood gases. Respiratory failure requires the use of assisted ventilation supervised by experienced personnel.

One must be alert to the possibilities of the complications of status asthmaticus and its therapy. Every effort must be made to prevent respiratory acidosis.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Rhinoplasty in the Mature Woman

ALVIN I. GLASGOLD, M.D., New Brunswick*

Rhinoplasty in the mature woman should be considered not only for improvement in nasal appearance, but also for its specific role in facial rejuvenation surgery. The technique is described.

Facial rejuvenation surgery concentrates on "face lift," blepharoplasty, chemical peel, and others. Rhinoplasty in the mature patient generally has been overlooked, possibly because it always has been associated with the very young. The appreciation of the aging effect of the nose on facial appearance has not been stressed. Aging produces a relaxation of the nasal tissues resulting in a general sagging of the nose, which is most evident in the large, dependent or bulbous nose. The overall effect is a downward rotation or drooping effect of the tip with a decrease in the nasolabial angle producing the appearance of a much longer sagging nose. This downward rotation and tip dependence can produce an apparent exaggeration of the bridge of the nose so that what was a small or inapparent hump suddenly becomes more obvious. The resultant effect on the face can be as much a sign of age as droopy lids or sagging skin (Figures 1,2,3).

Reversal of the aging effect on the nose can be as important or in some cases more important than the other cosmetic procedures utilized to rejuvenate the face. Limited rhinoplasty now is done more frequently as an adjunctive procedure in rhytidectomy. There are many individuals who are more aware of the cosmetic deficiencies produced by their nose than by the other aging features on their face. This may be because of long-time dissatisfaction with their nasal profile. With the general acceptance of cosmetic surgery in all age groups and both sexes, older individuals now request rhinoplasty independently—not necessarily for its rejuvenating effect but to have the nose or profile or appearance they wanted all their lives. The effect may improve appearance and can reverse an aging appearance as much as other forms of facial surgery. A significant contributing factor not to be overlooked is the positive psychological effect of rhinoplasty. The woman who presented a matronly appearance prior to surgery will change her facial cosmetics, hair style and dress all of which tend to hide other signs of aging. In earlier years rhinoplasty for someone over 50 years of age was considered a poor operation and the patient requesting this was thought to be psychologically unstable. Since other forms of facial cosmetic surgery on people in their 60's or older are used, there is no reason to exclude rhinoplasty. When properly done, it is a relatively simple procedure.

SELECTION OF PATIENTS

Health—Acceptable health is a factor at any age but certainly one must be more aware of it in the older patient. The healthy older patient does not present any undue surgical risk.

Psychologic Factors—Most mature women are very stable and realistic about their desire for facial improvement. They are usually readily satisfied with the improved ap-

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pearance and are much less picayune about small details than those patients undergoing "face lift" or blepharoplasty. The result of rhinoplasty is quite predictable and permanent, therefore care should be taken with the patient who says she does not want a different appearance. Do not be led into underdoing the nose and having a dissatisfied patient.

Expectations—There should be reasonable expectation that a desirable result can be achieved. Excessively thick skin is difficult to deal with at any age but in the mature woman it can make improvement impossible.

ANESTHESIA

Pre-operative sedation plus local anesthesia is utilized as in the younger age group. In anyone over 50 years of age, an anesthesiologist monitors the patient continuously throughout surgery even though supplemental anesthesia may not be necessary. The older patients are, as a rule, observed in the recovery room postoperatively for one to one and a half hours before returning to their rooms.

OPERATIVE PROCEDURE

Osteotomies and hump removal are handled in the usual fashion, but the latter should be conservative. The lower third of the nose requires the most judgment. The key factors in the older patient are the need to project and rotate the tip upward. There usually is a tendency to underexaggerate tip projection in the older patient. However because of the laxity of the tissue, this can lead to a poor result as the tip tends to fall back to its pre-operative level. I find the following technique useful in counteracting the postoperative sagging tendency in these patients:

1. A cartilage-splitting incision is utilized. The bulk of the lower lateral cartilage is removed leaving only a thin rim of lower lateral cartilage. The thicker the skin the less cartilagenous rim is left. In the thick-skinned individual the subcutaneous tissue of the tip can be trimmed for better draping.
2. A transfixion incision between the septum and columella is avoided unless the medial crura are long and the tip projection is excessive. This retains some support for the tip although preventing septal shortening.
3. Nasal shortening when desired occurs by:

(a) Transecting the lateral crura as part of the cartilage-splitting incision allowing the lateral legs of the nasal tripod to rotate upward.

(b) Shortening the projecting upper lateral cartilage which pulls the tip up.

(c) Utilization of a columella strut which rotates the tip cephalically.

4. The columella strut is taken from the lower portion of the septal cartilage through a separate short Killian incision. It is placed anterior to the medial crura from just above the premaxilla to the lobule. It does not enter into the lobule. This produces the following effects:

(a) Cephalic rotation of the nasal tip which shortens the nose without the necessity of shortening the cartilagenous septum.

(b) Prevention of postoperative drooping of the tip, which is especially useful in a heavy, dependent nose with short medial crura.

(c) A double-break curvature in the nose.

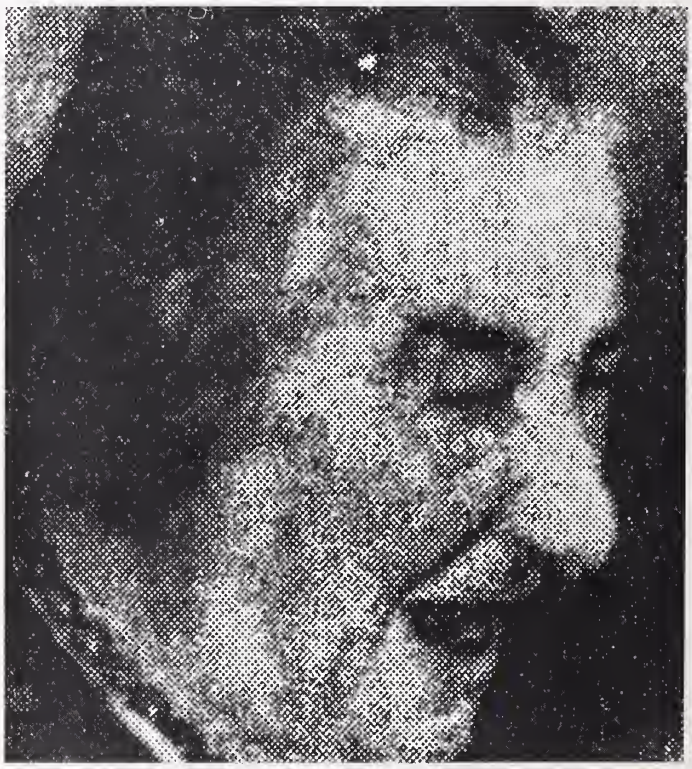
POSTOPERATIVE MANAGMENT

A standard nasal stent is used. The nose is never packed even when a submucous resection is performed as all incisions are closed and dead space eliminated by suturing the septal mucosa back to back. Enzymes are not utilized. The major factor in reducing postoperative swelling and ecchymosis is the careful handling of tissue and elimination of nasal packs.

Patients are usually discharged the day after surgery.

SUMMARY

Rhinoplasty in the mature patient can produce the desired enhancement of beauty and can be an effective means of facial rejuvenation. As such its value should be recognized along with the other surgical procedures utilized in facial rejuvenation. The importance of counteracting the effect of looser tissue in the older patient is stressed and a technique to solve this problem is described.



Figures 1,2—Changes in nasal appearance of a famous woman as aging process occurred.

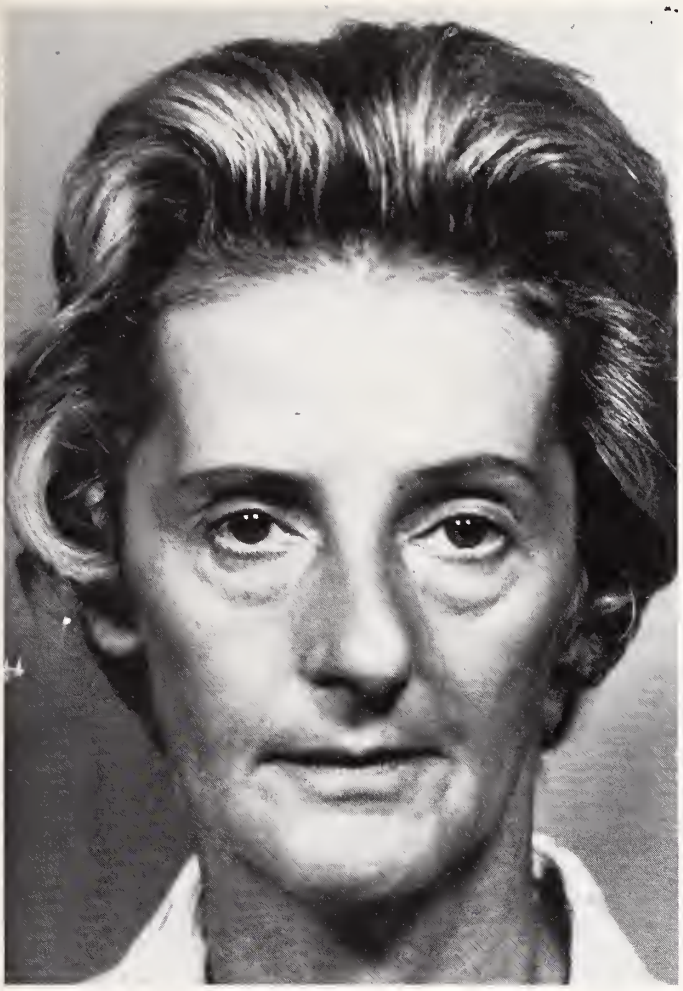
Pre and postoperative photographs illustrating improved appearance and more youthful look following rhinoplasty. Degree of change varies depending on age and the alteration in hair style and use of cosmetics.

Figures 3-A, B, C, D

Figures 4-A, B

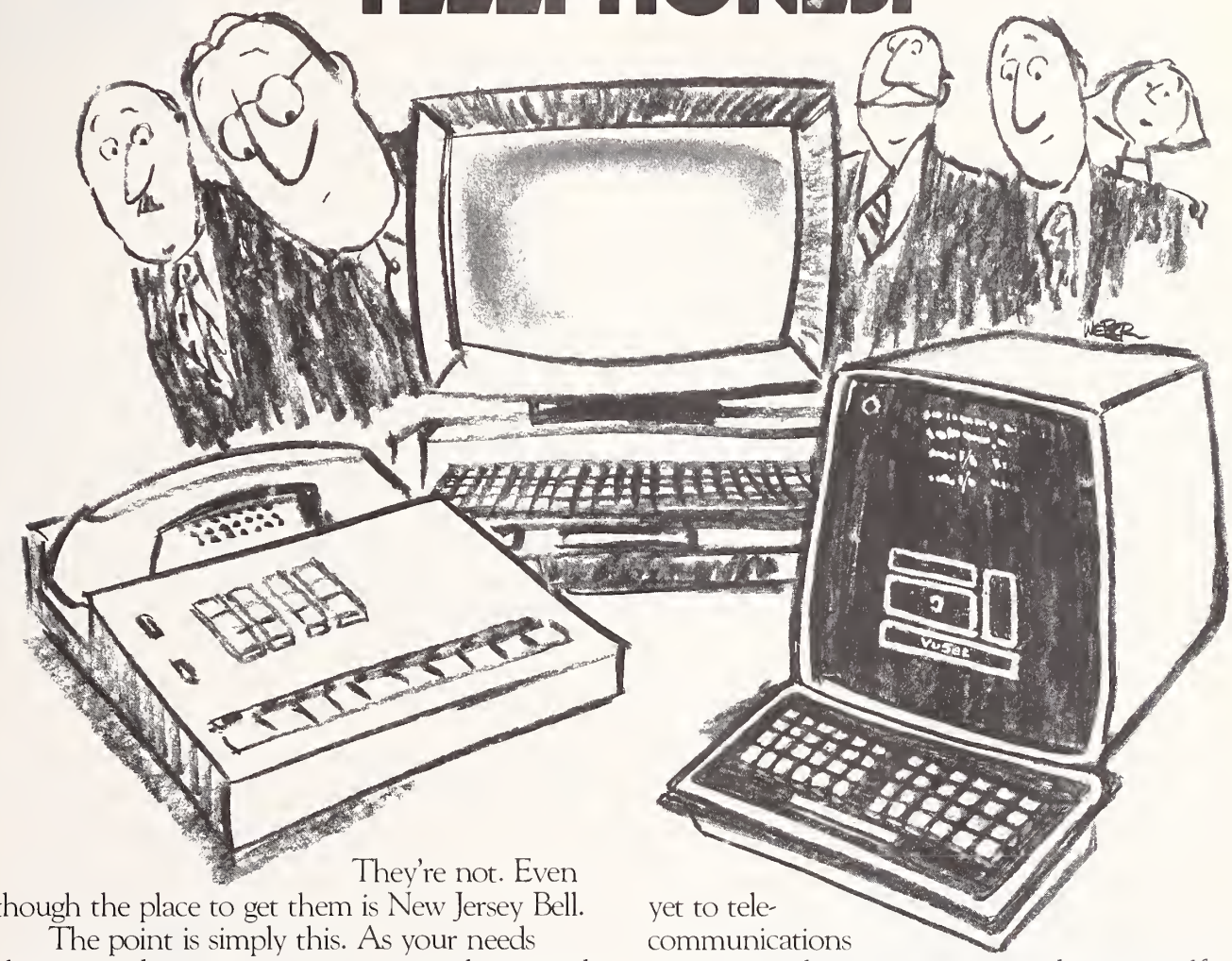
Figures 5-A, B

Figures 6-A, B, C, D



Figures 7-A, B, C, D

FUNNY, THEY DON'T LOOK LIKE TELEPHONES.



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The Catheter Care Team

EDWARD WAGMAN, M.D. and
ELAINE GOLDFARB, R.N., Paramus*

The Catheter Care Team is a practical, clinical approach to the problem of the long-term indwelling urinary catheter, particularly in large hospitals and extended care units. It can reduce urinary tract infection and its serious sequellae, be used as an educational and research tool, improve patient care and thus enhance the quality of life and self-esteem for institutionalized patients.

The April 1979 issue of this *Journal* included an article by Hirsch and Hirsch[1] whose clear implication was that American Medicine needed a more humanistic, compassionate approach both to patients and their families. They indicated that "many physicians lose interest when it is required only to relieve patients' ills and rarely consider comforting patients as their job."

It is in this context that we will describe an exciting study carried out at Bergen Pines over a ten-month period. The Catheter Care Team was used to deal with patients with long-term indwelling catheters and the associated problem of urinary tract infection and its serious complications, the emotional stresses upon the patient and often severe mechanical difficulties caused by the catheter itself.

THE STUDY

Microbiologic data correlating urinary tract infections and catheters were accumulated by the laboratory over a six-year period. The hospital authorities approved a pilot study to include four catheter care nurses and a physician. Those in the program included a group of female catheterized patients (ages 58-94) who required chronic catheterization, because of mulitple sclerosis (and neurogenic bladders) or stroke. They had severe disabilities, often were doubly incontinent and had infected urinary tracts, sometimes with two and three different organisms. They all experienced varying degrees of discomfort and mechanical problems due to the catheter.

The team was responsible for the daily irrigation of catheters to prevent blockage, changing of catheters at least twice a month or when necessary, procuring urine samples aseptically for analysis and culture, and delivering them to the laboratory. They also monitored patient fluid intake and output, perineal care, and, in some cases provided nutritional and fluid intake. Several patients required prolonged, time-consuming individual attention because of their severe disabilities. The team reviewed patient charts and recorded and collated all data obtained. They provided in-service training for nurses and students and were in almost daily contact with the physicians in charge who made regular rounds. Appropriate anti-microbials were administered as required.

RESULTS

The results as viewed at the end of ten months were quite dramatic, rewarding and gratifying to all concerned. Urinary tract infection was diminished in most patients. Pain, discomfort, leakage, bladder spasms, blockage, spontaneous expulsion and hematuria were markedly decreased. The distressing odor of urine, which was usually with the patients everywhere at all times was decreased sharply or eliminated. Better perineal care significantly lessened the chances of decubitus ulcers. The patients had greater self-esteem and

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> **"Urinary tract infection was diminished in most patients. Pain, discomfort, leakage, bladder spasms, blockage, spontaneous expulsion and hematuria were markedly decreased."**

> **". . . a properly trained and motivated catheter care team is a practical, clinical approach to the many problems of long-term indwelling catheters."**

appeared more cheerful. The quality of their life was noted by the nursing staff, the catheter team and the attending physicians concerned to be substantially improved. Nursing care, in general, was facilitated.

DISCUSSION

The value of the catheter care team approach in this country, has been emphasized by Lindan[2,3] working in an institution which is devoted to the rehabilitation of the chronically ill patient. The rationale for such a team was the increasing evidence that total prevention of infection was possible in some patients. There was dissatisfaction with the poor and variable techniques in related areas of care and the collection of specimens, wastage and improper usage of equipment by unskilled personnel, and a lack of a coordinated program for bladder retraining and the removal of catheters.[4] Kunin affirmed the wisdom of hiring and training a special catheter care team for extended care institutions and large hospitals, as well, since he felt that the level of care could be improved greatly by a well-motivated and specialized group.[5] Strong physician direction and support is needed. The Communicable Disease Center stated that catheters should be inserted only by adequately trained personnel or, if practical, by a team of specific individuals given the responsibility for catheter insertion and maintenance. Catheter-associated gram negative sepsis has a 20 to 50 percent mortality. Pearman, in Australia, considers the catheter care team essential for rehabilitation of neurogenic bladder patients.[7] Morgan described the gradual reduction of the number of patients with catheter infection using the catheter care team in the extended care department of Sunnybrook Medical Center in Canada.[8] Similar teams have been developed in the United States in hospitals in Ohio, California, Florida and Alabama. Griffith, commenting on the medicolegal implication of infection control, pointed out that a hospital which supplies non-sterile facilities or equipment, or permits conditions to exist whereby infection can occur, would be in violation of legal duties to its patients.[9] Vigilance against these problems would of course be necessary. The author queried whether the failure of hospital authorities to fund any such infection-control programs would increase legal risk.

SUMMARY

The catheter care team was utilized for the care of a group of severely disabled, incontinent, elderly female patients, chiefly with stroke and multiple sclerosis (with neurogenic bladders) and urinary tract infections over a one-year period.

The findings in this study reinforce the results and conclusions of others: that a properly trained and motivated catheter care team is a practical, clinical approach to the many problems of long-term indwelling catheters. Strong physician direction and support is essential. Such teams can help to reduce urinary tract infections and their serious complications. They can be used as an educational and research tool. The experience at Bergen Pines also has shown that the quality of life and emotional state of the patient can be enhanced significantly. This observation apparently has not been commented upon previously by other authors.

We feel that any program which can improve patient self-esteem and facilitate his ability to deal with the environmental distresses of prolonged institutionalization is requisite. This program reemphasizes the principle by Hirsch and Hirsch that when modern medicine cannot cure, symptomatic relief and comfort can be provided in most cases.[1] This is commensurate with the basic tenet of the Hippocratic Oath and recognizes that medicine is both an "art," as well as a "science." The catheter care team is one approach to this goal and should be considered as a real alternative in large hospitals and, particularly, in extended care facilities where urinary catheterization presents so many problems common to the patient, nursing staff and clinicians alike.

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Sarcoidosis of the Colon*

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Sarcoidosis of the colon has been reported in very few instances. The clinical picture may mimic a colonic neoplasm. This brief report outlines such a case of sarcoidosis of the colon and summarizes the few similar cases which previously have been reported.

Sarcoidosis can have protean manifestations. In the case history presented below, an unusual finding was that the disease involved the colon, and mimicked a neoplastic lesion.

CASE REPORT

A 55-year-old black woman, previously well, was hospitalized for evaluation of anorexia and a 30-pound weight loss occurring over a six-month period before admission. This problem began immediately after the death of her father. The patient was depressed, but the systems' review was unremarkable. There were no abnormalities detected on the physical examination except for bilateral asymptomatic parotid gland enlargement.

The following studies were normal: complete blood count, urinalysis, screening chemistry profile, thyroid studies, electrocardiogram and serologic test for syphilis. The intermediate PPD test was negative at 48 hours. The Westergren sedimentation rate was 38 mm/hr. The electrolytes were normal except for the serum calcium which was 12.1 mg/dl.

The chest x-ray showed bilateral diffuse interstitial and nodular parenchymal abnormality. Nodules measured three to ten mm. in diameter. Hilar areas were enlarged and prominent. The radiographic picture was suggestive of sarcoidosis. Upper gastrointestinal series was normal. The oral cholecystogram showed poor visualization of the gall bladder with multiple intraluminal gallstones. A sonographic study of the abdomen showed a contracted gall bladder containing stones. In addition, there was a localized enlargement of the body of the pancreas measuring 2.75 x 4.5 cm. and suggestive of pancreatic neoplasm. Barium enema examination showed a stenotic area in the proximal sigmoid colon suggestive of an annular neoplasm (Figure 1).

Because of the abnormal sonographic and barium enema findings, an exploratory laparotomy was performed. The surgeon found the liver to be diffusely involved with an infiltrative process consisting of multiple light yellow nodules scattered throughout the organ. The gall bladder contained stones. No pancreatic abnormality was found, but a large lymph node four by nine cm. overlay the pancreas, and was probably responsible for the abnormal sonographic findings. Additional nodules were scattered throughout the retroperitoneal area and on parietal and visceral peritoneum. In the proximal sigmoid colon a firm mass was noted to surround a narrowed lumen for an eight cm. length. The surgeon performed a cholecystectomy, excised the large peripancreatic lymph node, performed a liver biopsy and resected the abnormal portion of sigmoid colon.

Tissue examination showed the gall bladder wall to be chronically inflamed; all other tissues removed, including the colon (Figure 2), showed findings typical of sarcoidosis with

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Figure 1—Barium enema study showing narrowed area of rectosigmoid.

multinucleated giant cells and surrounding fibrotic connective tissue. Schaumann bodies were seen.

The patient's postoperative course was smooth. Corticosteroid therapy was administered for high serum calcium. Hypercalcemia reverted to normal after the third day of this treatment. She was discharged to home care on the 15th hospital day. A followup evaluation three months following discharge from the hospital found her to be symptom-free and regaining previously lost weight.

COMMENT

This patient underwent diagnostic studies because of weight loss and anorexia. Although initially suspected of having a malignant disease, she was found to have widespread intro-abdominal sarcoidosis, including a constricting colonic lesion which superficially resembled carcinoma. The relationship between her presenting symptoms and the subsequent finding of sarcoidosis was undetermined.

Sarcoidosis of the gastrointestinal tract is rare. A review of

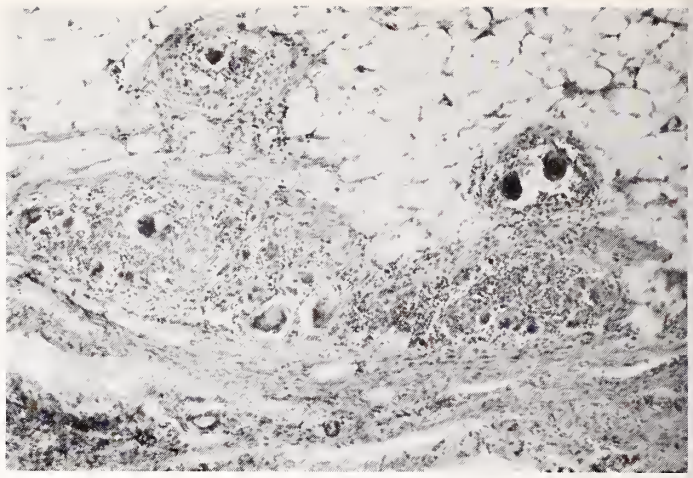

Figure 2—Photomicrograph of section of colon showing multiple noncaseating granulomas characteristic of sarcoidosis (x 140).

published series of large numbers of cases of sarcoidosis suggests that either no involvement of the gastrointestinal tract is present[1] or that, in very infrequent instances, there is involvement of the stomach[2] or small intestine[3-5]. Involvement of the colon in sarcoidosis appears to be even more unusual. In the few cases reported, the predominant clinical feature is that of a colon lesion radiographically resembling a carcinoma and discovered unexpectedly during diagnostic study for other disease[6-10]. The case history outlined above is another instance of this almost unique occurrence.

SUMMARY

At exploratory laparotomy, a woman was found to have a stenosing lesion of the colon, grossly resembling a carcinoma. Microscopic examination showed findings typical for sarcoidosis. The rarity of this finding is underscored by the paucity of reported cases.

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Mesenteric Cysts: Report of Three Cases Including One Producing Bilateral Ureteral Obstruction*

A. J. PELIAS, M.D., J. H. JACOBY, M.D.,
R. J. SCHIFFMAN, M.D., and R. C. CAMISHION, M.D., Camden

Three case reports of patients with mesenteric cysts are presented. In one the cyst caused bilateral ureteral obstruction. The pertinent literature is reviewed. When a cystic abdominal mass is encountered clinically, mesenteric cyst should be a prime consideration. The diagnosis is aided by barium enema, intravenous pyelography, arteriography and ultrasonography. Preferably treatment is by enucleation of the cyst, if possible.

Cysts of the mesentery are uncommon, the reported incidence varying from one in 30,000 to 250,000 hospital admissions.[1] The problem often is an abdominal mass which may or may not be producing symptoms.[1-4] Mesenteric cyst often is not suspected so the diagnosis most commonly is made at operation.

Mesenteric cysts occasionally cause unilateral ureteral obstruction,[3] but we have not been able to find reported in the literature a case where bilateral ureteral obstruction was produced. We have encountered such a patient and have had experience with two other patients who presented with asymptomatic abdominal masses. These cases form the basis of this report.

CASE REPORTS

Case 1—An 80-year-old female was admitted to Cooper Medical Center because of a severe urinary tract infection. She had had an appendectomy, cholecystectomy and hysterectomy, but it could not be determined whether or not an oophorectomy had been performed.

Physical examination revealed an asthenic woman with a readily palpable, slightly tender, lower abdominal mass, which seemed to rise from the pelvis and reach the umbilicus. Laboratory findings were noncontributory.

A plain film of the abdomen revealed a soft tissue pelvic mass which displaced the bowel upwards. Intravenous pyelogram demonstrated bilateral ureteral obstruction at the pelvic brim with marked hydronephrosis and hydroureters (Figure 1). Barium enema disclosed an extrinsic mass compressing the sigmoid colon (Figure 2). A B-mode pelvic and abdominal ultrasound revealed a 15 x 7.5 x 18 cm cystic mass filling the lower abdomen and pelvis (Figures 3a, b).

Surgery was performed on May 25, 1978, with a preoperative diagnosis of ovarian cyst or mesenteric cyst. A large cystic mass (Figure 4) filling the lower abdomen and extending deep into the pelvis was found. A dissection plane about the cyst was developed and the cyst was enucleated from the mesentery of the sigmoid colon. There was no gross evidence of retained ovarian tissue in the pelvis. During the procedure, both ureters were visualized; they were about two cm in diameter and were compressed by the cyst at the brim of the pelvis.

The excised specimen consisted of a multilocular, translucent, thin-walled cyst with several blood vessels on its external surface. The cyst measured 22 x 19 x 10 cm. and weighed 1366 grams. Its wall measured less than one mm. in greatest thickness and it was filled with watery colorless fluid. Microscopically, the wall was composed of connective tissue and lined, for the most part, by a single layer of flat cells resembling endothelial cells. In some areas, the cells were taller and varied from cuboidal to columnar. Many of

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ntravenous pyelogram demonstrating rather marked dronephrosis and hydroureter down to the level of rim. Arrows surround a large mass extending out of nd also causing extrinsic pressure on the urinary

Figure 2—Barium enema disclosing extrinsic pressure primarily upon the sigmoid and descending colon by an enlarged mass extending out of the pelvis as indicated by the arrows.

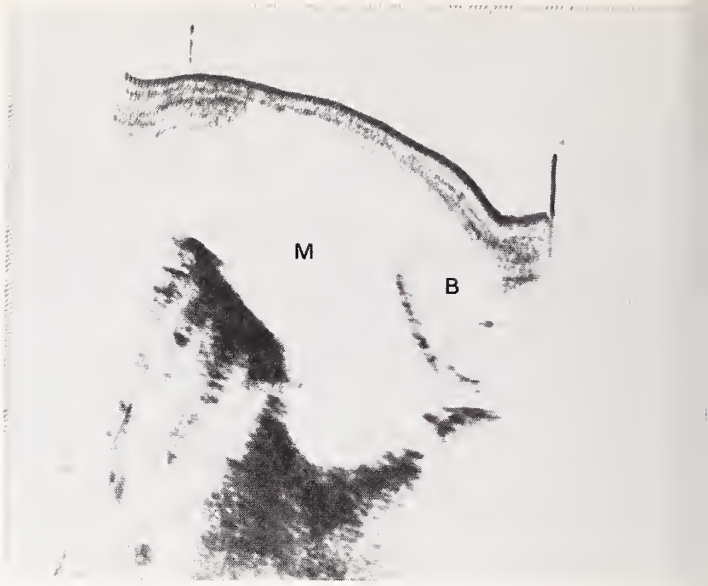

Figure 3a—Longitudinal B-mode sonogram demonstrating a large cystic mass (M) extending from the pelvis, posterior to the bladder (B), to a level just above the umbilicus. A Foley balloon is in the inferior portion of the bladder.

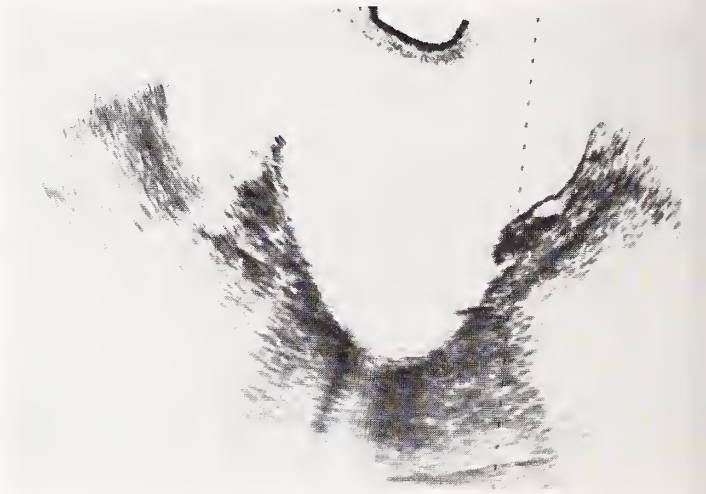

Figure 3b—Transverse sonogram demonstrating the huge proportions of the cystic mass which assumes a very lobulated contour.

Figure 4—The gross specimen of the intact mesenteric cyst. Note the multilocular cystic structure.

Figure 5—A post-evacuation film on a barium enema study disclosing a soft tissue mass marked by arrows displacing both the small bowel and part of the partially filled large bowel toward the left.

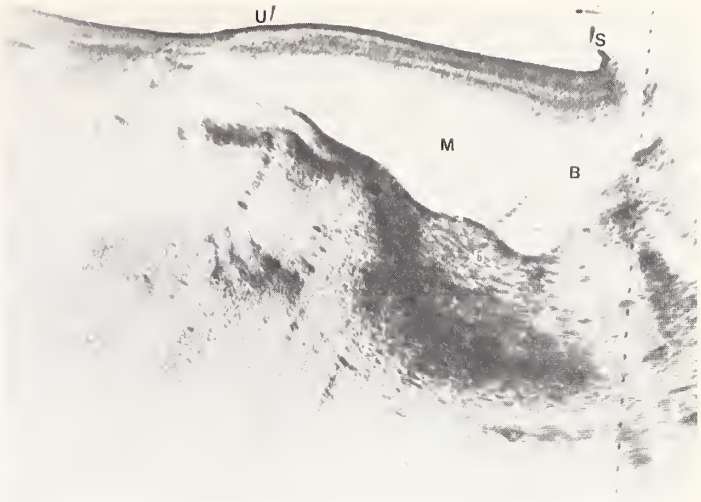

Figure 6a—Longitudinal B-Mode sonogram demonstrating a large cystic mass (M) extending from the pelvis to a level above the umbilicus (Black U). This compresses the urinary bladder (B) and displaces it slightly posteriorly. S-symphysis, White U-uterus.

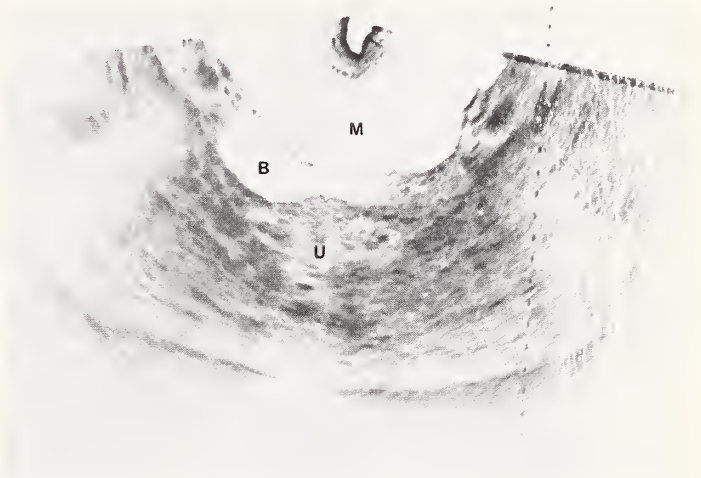

Figure 6b—Transverse sonogram demonstrating the large cystic mass (M) insinuating itself anteriorly to the urinary bladder (B). U-uterus.

the columnar cells were ciliated. Few small daughter locules tended to be lined by simple ciliated columnar cells. The nuclei were oval, bland and displayed no mitotic activity.

The postoperative recovery was uneventful, and the pyelonephritis promptly subsided.

Case 2—A three-month-old girl was admitted to Cooper Medical Center after a movable, soft abdominal mass was found in the right lower quadrant on routine physical examination. Laboratory data were unrevealing.

An intravenous pyelogram revealed deviation of the right ureter laterally. A barium enema showed evidence of displacement of the colon by a large, right lower-quadrant mass (Figure 5).

At operation on April 28, 1976, a large cyst attached to the omentum readily was excised with a segment of the omentum. The postoperative course was uneventful.

The pathologic specimen consisted of an 8 x 7 x 5 cm. cyst with an attached pedicle measuring 8 x 0.3 cm. Externally, the cyst was smooth and its wall measured one mm. in greatest dimension. The lumen was filled with amber serous fluid and the lining was smooth except for small areas covered by brown ointment-like material.

Microscopically, the cyst wall was composed of connective tissue and lined by a single layer of cells that varied in height. Some of these resembled epithelial cells while others were cuboidal. Large areas of the lining were destroyed by hemorrhage and proliferating fibroblasts were organizing the blood clot. Hemosiderin-containing macrophages in the wall suggested old hemorrhage. In addition, multiple large foci of calcification were noted in the cyst wall. Small, daughter locules were lined by simple columnar cells. The nuclei were oval, bland and displayed no mitotic activity.

Case 3—A 55-year-old female was admitted to the gynecology service of Cooper Medical Center because a mass was found on abdominal and pelvic examination. The laboratory studies were unremarkable.

An intravenous pyelogram showed a pelvic mass causing pressure on the bladder posteriorly. A B-mode echogram showed a 17 x 16.5 x 6 cm cystic mass filling the upper pelvis and lower abdomen (Figures 6a, b).

On September 18, 1978 surgery was performed with a preoperative diagnosis of ovarian cyst. Upon opening the abdomen, a large cystic mass was found in the pelvis. A dissection plane could be developed and the cyst readily was enucleated. The mass originated in the mesentery of the sigmoid colon.

The excised specimen consisted of a thin-walled cyst measuring 15 cm. in diameter. Both the external and internal surfaces of the cyst were smooth and the cyst was filled with colorless watery fluid. Microscopically, the cyst wall was composed of connective tissue and was lined by a single layer of cells that varied in height. In most areas, the cells were flat, resembling endothelial cells. In other regions, the cells were

taller and almost cuboidal. Rare foci displayed more than one layer of lining cells. In these regions, there was a maximum thickness of four cell layers. The nuclei were oval, bland and displayed no mitotic activity.

Postoperatively the patient's course was uneventful.

DISCUSSION

The etiology of mesenteric cysts has been discussed thoroughly in a publication by Ford.[5] Some investigators suggest that the cysts may originate from an embryologic developmental abnormality, some postulate that the cyst results from trauma, and others propose that the cyst is caused by mechanical obstruction of the lymphatics.[6-9] Ford, in his publication, also presented a comprehensive classification of mesenteric cysts. Burnett *et al*[10] presented a collected series of cases and discussed the most common presenting symptoms and the sites of origin of the cysts. In 1974, Caropreso[11] reviewed the literature and was able to collect about 550 to 600 cases.

The diagnosis of mesenteric cysts is greatly facilitated by ultrasonography. Barium enema, intravenous pyelogram and arteriography may help to confirm the nature of the mass.[3-12] Mesenteric cysts commonly present as pelvic masses and often cause deviation of the ureters but rarely cause hydronephrosis. Bilateral ureteral obstruction occasionally is caused by ovarian or uterine tumors, but, to our knowledge, case one of this report is the first case of bilateral ureteral obstruction caused by a mesenteric cyst.

In Bearhs' series of nine cases, only one patient was diagnosed correctly preoperatively.[6] The usual differential diagnosis includes ovarian cyst, pseudocyst of the pancreas, pedunculated fibroid cyst, lipoma of the mesentery and omental cyst.

Mesenteric cysts are best treated by surgical excision, first to confirm the diagnosis, and second to prevent complications such as rupture, hemorrhage, intestinal obstruction or obstructive uropathy. In our three cases, enucleation of the cyst was accomplished easily because the cyst was surrounded by a pseudocapsule of compressed structures, allowing the development of a dissection plane. By remaining within this plane, damage to surrounding structures, particularly the ureters and mesenteric vessels, can be avoided. In our opinion, if this can be done, it is the preferred method of treatment.

One note of caution is to avoid confusion between a mesenteric cyst and an enteric cyst. The latter cannot be treated by simple excision because the cyst and bowel have a common wall and blood supply. In Burnett's series of 200 collected cases the mortality for marsupialization was four percent, enucleation seven percent, resection 16 percent, aspiration 33 percent, and simple drainage 60 percent.[10] Overall reported mortality rates have varied from 6.9 to 60 percent.[11] It seems obvious that mortality rates should be much lower than this, although experience with only three cases does not permit us to draw this conclusion.

SUMMARY

Mesenteric cysts are uncommon and the diagnosis often is not made during the preoperative evaluation of an abdominal mass. Three such patients are reported herein; two had asymptomatic abdominal masses and one had an abdominal mass producing bilateral ureteral obstruction.

The etiology of mesenteric cysts, the clinical picture observed in our cases and in those reported in the literature, are reviewed. The method of diagnosis by barium enema, intravenous pyelography, arteriography, and ultrasonography is discussed. The various forms of surgical treatment are outlined. In our opinion, if it can be done, a plane is developed between the cyst and the surrounding pseudocapsule and the cyst enucleated. This was performed without difficulty in our three cases with good long-term results.

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Direct Current Electrical Stimulation of Bone Growth: Review and Current Status

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Basic research conducted over the last several decades suggests that the primary biological signal triggering the growth of bone and directing its remodeling is associated with the fundamental electrical nature of bone. Further, it has been demonstrated that an externally applied electrical signal can stimulate growth in otherwise dormant bone. These concepts have led to the development of direct current electrical stimulation devices for the clinical treatment of fracture non-unions.

Bone is a dynamic living material. As such, it responds to various stimuli. The response may be growth, repair or remodeling depending on the particular form of stimulus. For example, consider malalignment in a healed fracture of a long bone. Provided angulation is not too severe, the bone will straighten with time. This is an example of "Wolff's Law" or adaptive remodeling. New bone is laid down on the concave surface of the angulation. Mechanically redundant bone is resorbed from the convex surface. The bone clearly is responding to the unusual state of bending stress present in the angulated bone by remodeling to relieve or minimize this stress.

A fundamental question arises from observation of this phenomenon. What is the nature of the signal which so carefully directs bone deposition and resorption?

It can be postulated that the state of stress is the primary physical signal recognized at the cellular level. Under certain conditions of stress, bone is stimulated to hypertrophy. Unstressed bone is directed toward atrophy. However, no mechanism for direct cellular recognition of stress is known to exist in bone. Further, consider the fresh fracture. The stress field is thoroughly disrupted and often discontinuous at the fracture site; yet osteogenesis is stimulated and directed. This suggests that, although bone clearly responds to stress, stress is not the direct mediator of changes in cellular activity.

Is there a signal common both to remodeling and primary fracture healing? Such a signal must be a physical stress analogue and must also be present at a fracture site. Data amassed over the past several decades suggest such a signal does exist and is associated with the fundamental electrical nature of bone.

REVIEW

In 1953, Fukada and Yasuda demonstrated that stressed bone generates an electric potential.[1] This stress-generated potential is present in bone regardless of viability or state of hydration. Since this early investigation, stress-generated potentials have been studied extensively.[2-6] In general, the studies indicate that a bone stressed in bending develops a negative electric potential on the concave, compressive side, relative to the convex, tension side. Other experiments employing stress modes other than bending yield similar results.[7-8] On a macroscopic scale, areas of compression are electronegative with respect to areas of tension.

Recently Steinberg *et al.* have investigated the origin of stress-generated potentials.[9-10] It would appear that these potentials do not arise from the classic piezo-electric phenomenon associated with appetite crystalline structure,

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"In 1953, Fukada and Yasuda demonstrated that stressed bone generates an electric potential."

". . . two direct-current bone growth stimulation systems are commercially available as investigational devices pending approval by the . . . (FDA)."

but the potentials are associated with the collagen fraction of bone.

Soon after this stress-generated potential phenomenon was confirmed, it was recognized that this electrical stress analogue could contain the information necessary to direct the remodeling process. If stress-generated potentials do control the remodeling process, then what is the role of electrical potential in fracture healing?

In earlier experiments Freidenberg and Brighton determined that even in unstressed bone, areas of active bone growth and repair are electronegative with respect to less active areas.[11-12] In these experiments the electric potential of the viable long bones of immature rabbits was mapped. The potential relative to a reference electrode placed in the diaphysis was plotted versus position along the bone. The active growth region about the epiphysis was found to be consistently electronegative with respect to the diaphysis. Bones fractured in the diaphysis displayed a different pattern. These bones were found to be extremely electronegative in the region of the fracture site. Unlike stress-generated potentials, these so-called bioelectric potentials are dependent on cellular viability and disappear several hours after death. The source of these bioelectric potentials is not understood.

Although stress-generated potentials and bioelectric potentials would seem to have unrelated sources, their appearance and character suggest they may be the primary signals directing remodeling and triggering repair and growth. That is, electronegative, stress-generated potentials are induced where bone deposition should occur in remodeling. Electronegative bioelectric potentials are associated with areas of active bone growth or repair. This evidence is not definitive, however. A cause and effect relationship between electronegative potential and bone growth remains unproved.

Based on this powerful circumstantial evidence, researchers have posed the following question: If the primary signal for remodeling or growth is electrical, can an applied signal promote or enhance bone growth? Numerous experiments utilizing animal models have answered the question in the affirmative.

Particularly illustrative is the work of Freidenberg and coworkers.[13] Using a rabbit model, the researchers clearly demonstrated that small 20 μA. direct currents could stimulate the growth of bone. This growth occurred about the cathode or negative electrode when that electrode was implanted in the medullary canal of a long bone. This work recently has been duplicated in our laboratory and has been shown to be accurate and highly reproducible.[14]

Based on such laboratory studies, researchers have moved to clinical evaluation of electrical stimulation. Most studies have centered about treatment of difficult orthopaedic problems which are resistant to other procedures. Non-unions, pseudoarthroses-delayed unions and congenital pseudoarthroses have been treated. More success has been achieved in treating fracture non-unions, however.

Brighton *et al.*, using a multiple percutaneous electrode method, have treated more than 200 non-unions.[15,16] The rate of clinical union approaches 85 percent. This success rate is similar to that associated with other surgical procedures. This is an impressive achievement when one considers that most of the patients involved in this study had had previous surgical treatment.

Parsons and Weiss, using the same techniques and hardware, have reported comparable rates of success in a smaller series.[17] Patterson *et al.*, have treated numerous non-unions using another method of direct current electrical stimulation.[18] Conceptually, the device is similar to that used by Brighton and co-workers. It differs in that it is a single electrode, fully implantable device. Animal studies in this laboratory suggest that the device is effective in stimulating bone growth.[14] Rates of clinical success reported by Patterson support the effectiveness of this device.

A multiple (4) cathode version of this fully implantable device also has been used to encourage solid fusion in spinal surgery.

CURRENT STATUS

At the time of writing, two direct-current, bone-growth stimulation systems are commerically available as investigational devices pending approval by the Food and Drug Administration (FDA). Such approval is required prior to the unrestricted release of the product to the medical community.

The first system† is based on the work of Brighton[15,16]. Basic hardware consists of a hermetically sealed battery pack with solid state control circuitry (Figure 1). Through insulated connections, the pack delivers 20 μA. of constant direct current simultaneously to each of four cathodes. There are leads for monitoring total current. The cathodes are insulated stainless steel Kirschner wires having a one cm. uninsulated tip. The anode is an adhesive conducting gel pad to be placed on the skin and changed regularly by the patient during the course of treatement.

Briefly, the system is utilized in the following way. The cathodes are inserted under x-ray control into the non-union site. The cathodes then are connected to the battery pack. The pack and cathodes are incorporated in a cast, leaving the monitor wires available for testing of the system. Anterior-posterior and lateral x-rays of a non-union of the tibia with percutaneous cathodes and stimulator are shown in Figure 2.

After 12 weeks of immobilization (non-weight bearing) the stimulation is complete and the cast and cathodes are removed. The patient is then placed in a weight-bearing cast for up to 12 weeks. Immobilization times after stimulation

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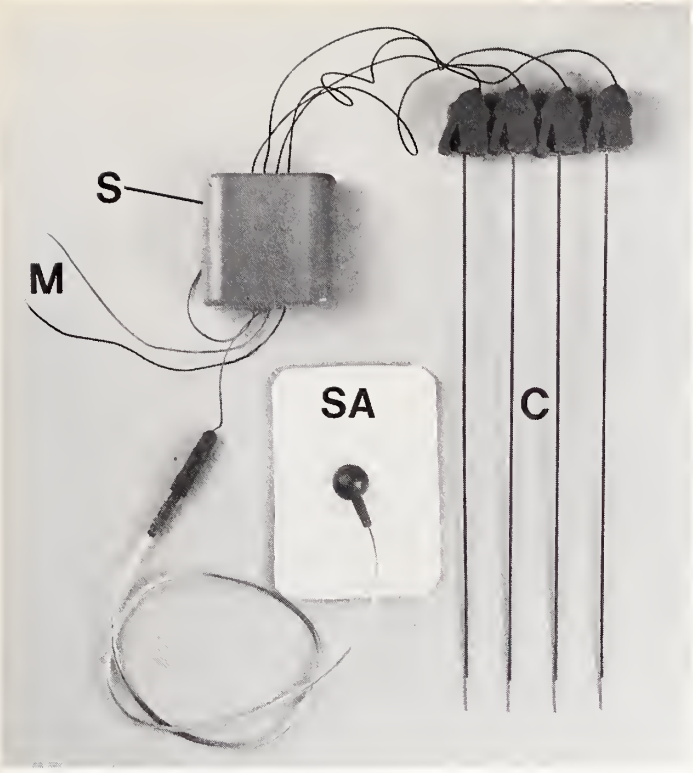

Figure 1—Semi-invasive electrical bone growth stimulator. The components are a sealed stimulator (S) containing batteries and control circuitry, insulated percutaneous cathodes (C) and an adhesive skin anode (SA). The performance of the device can be monitored through wires (M).

vary according to the individual and bone involved and must be based on radiologic appearance of the fracture.

The second system‡ is based on the work of Patterson.[18] The device is a constant current (20 μA) single cathode device. The solid state control circuitry and batteries are encapsulated in medical grade silicon resin with an cylindrical outer case of titanium (Figure 3). The cathode is a stranded titanium wire 40 cm. in length. The last 25 cm. are uninsulated. The anode is short (two cm.) and consists of insulated, stranded titanium wire with a plantinum tip of 70 mm^2 surface area. The device is fully implantable.

This stimulation system is used in the following way. The fracture site is surgically exposed. A small block of bone is removed from across the non-union site. The cathode wire is wound into a helix and placed in the cavity formed by the excision of the bone. An alternate method of cathode placement is simply to drill two holes across the non-union and thread the cathode wire through these holes in a figure-of-eight pattern. The anode is placed in soft tissue as is the stimulator. For instance, with a tibial non-union, the stimulator and anode can be placed conveniently between the gastrocnemius and soleus. Anterior-posterior and lateral x-rays of a tibial fracture with implantable stimulator in place are shown in Figure 4.

The stimulation takes place over 12 to 20 weeks. The stimulator then is removed surgically. At this point, the helical titanium cathode is firmly encased in bone and is left behind. Protected weight bearing is encouraged until adequate bone strength is regained as determined by x-ray.

Both methods of direct current bone growth stimulation, the semi-invasive and the totally invasive, are undergoing clinical trial at medical centers in the United States and abroad. Consequently, large clinical series are rapidly being developed. The FDA is examining these data. The semi-invasive device is expected to be approved for unrestricted commercial sale to the medical community, before this article reaches press. Approval for the invasive device will, no doubt, follow.

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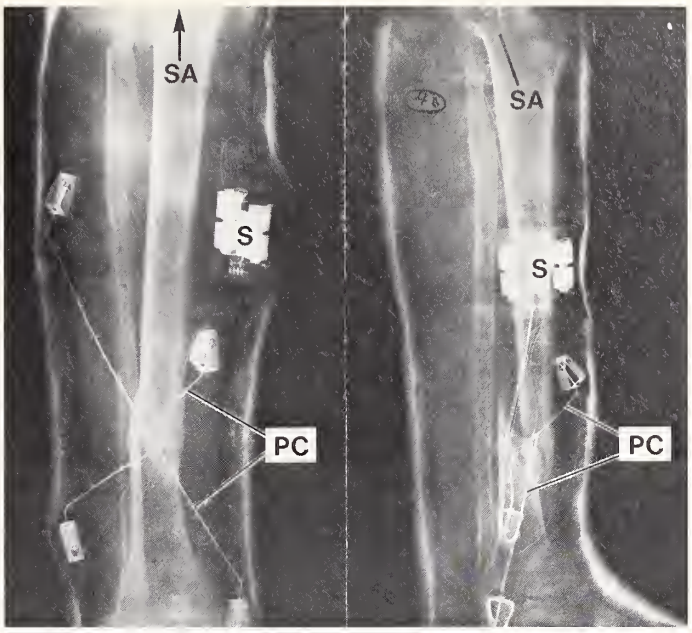

Figure 2—Anterior-posterior and lateral x-rays of a tibial non-union detailing placement of percutaneous cathodes (PC) in non-union site. The stimulator (S) is incorporated in the cast. An adhesive, skin anode (SA) is placed proximally on the thigh and changed regularly by the patient (Parsons and Weiss[17]).

DISCUSSION

Clinical trials thus far completed indicate both methods of direct current electrical stimulation are effective modes of treatment for non-union. Rates of success in healing non-unions were similar to rates reported for other surgical procedures such as bone grafting, and others. These are particularly impressive results as electrical stimulation was often the procedure of "last resort." Many of the patients in these series had multiple surgical procedures prior to electrical stimulation.

Both of the methods described have specific advantages and disadvantages. Indications for use of a particular method depend on the patient and the exact nature of his orthopaedic problem. For instance, an intelligent, cooperative patient with an uncomplicated tibial non-union can be treated quite effectively using the multiple cathode percutaneous method. This method does require active participation of the patient in his treatment. The patient must understand the importance of changing the skin anode regularly. The logistics and cost of an adequate supply of anode pads must be considered. Also weight bearing during the stimulation phase of treatement can result in fatigue failure or dislodgement of the percutaneous cathodes. Failure of the anode lead wire is not uncommon if the patient is not careful in changing the anode pad. However, given a

"Clinical trials indicate both methods of direct current electrical stimulation are effective modes of treatment for non-union."

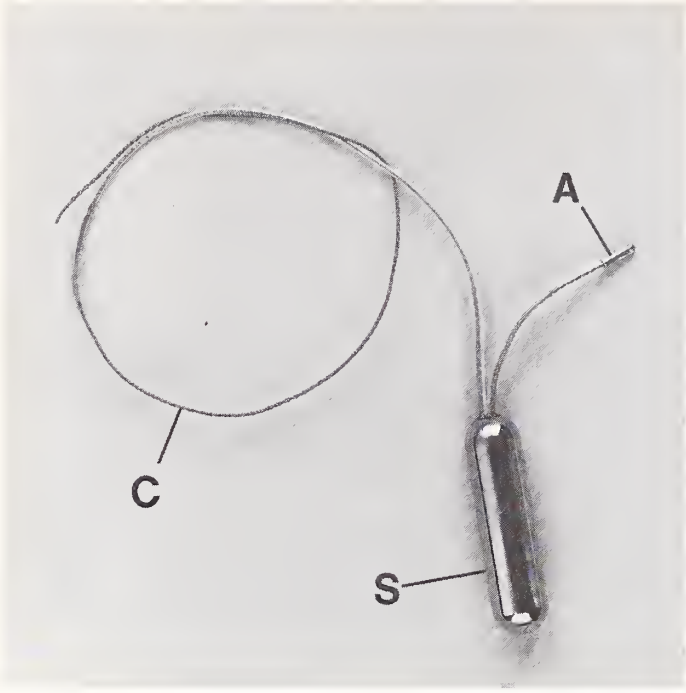

Figure 3—Fully implantable electrical bone growth stimulator. The device consists of a sealed stimulator (S), a platinum anode (A) and a titanium cathode (C).

reliable conscientious patient, the great advantage of this method is the simple, benign cathode insertion procedure. In the operating room the cathode pins often can be inserted, using a local anesthetic. The benefit/risk ratio for such a procedure is thus quite high.

When facing a difficult, unstable non-union where surgical intervention is indicated, use of the fully implantable device can be justified. In such a case the non-union can be surgically prepared to accept the stimulating cathode under direct visualization. Following surgery, there is no patient involvement. For the unreliable patient or the patient where surgery is already indicated, the implantable stimulator may be the device of choice.

CONCLUSION

It is clear from the above discussions that the direct current electrical stimulation of bone growth is an effective, innovative treatment for fracture non-unions. Two stimulation systems are commercially available as investigational devices pending approval by the Food and Drug Administration. Based on results of completed clinical trials, approval for commercial sale of these devices seems imminent.

Addendum: As this article goes to press, both methods of direct current stimulation have been approved by the FDA for commercial sale. *The authors*

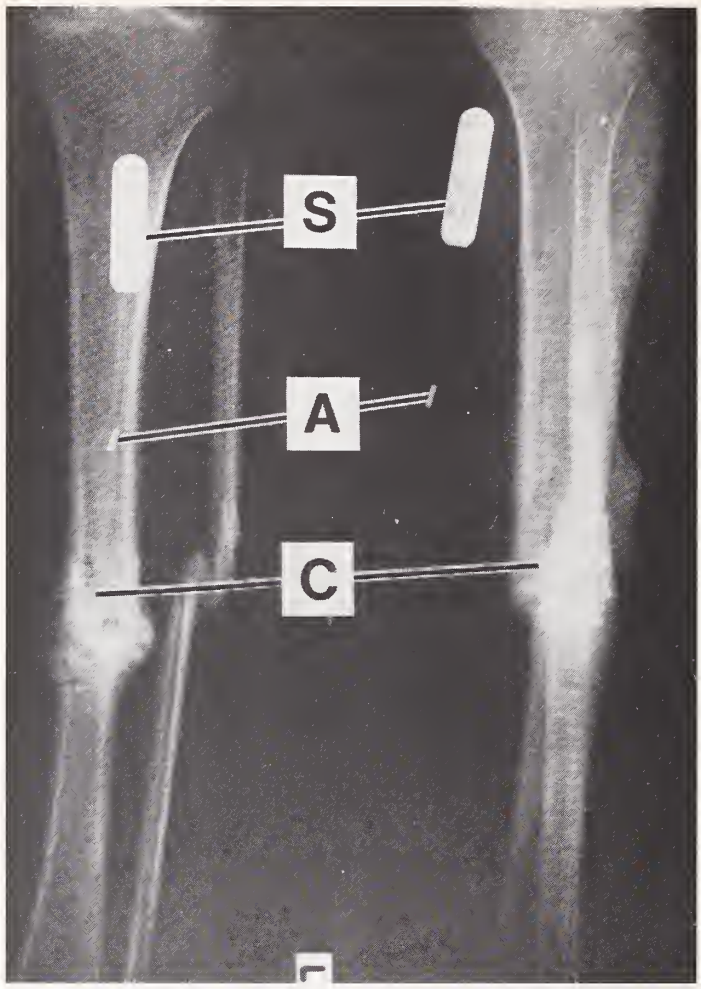

Figure 4—Anterior-posterior and lateral x-rays of a tibial fracture detailing placement of the helically wound titanium cathode (C) in the prepared fracture site. The stimulator (S) and anode (A) are placed in the soft tissues proximally (Osteostim™).‡

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Intermittent Trifascicular Block

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Electrocardiograms (ECGs) A and B were taken several days apart in the same 68-year-old man admitted to the hospital because of syncope (Figure 1). In tracing A, the limb leads show an abnormal degree of right axis deviation, QRS prolongation, small but definite q-waves in leads II,III and aVF and initial r-waves in I and aVL. The percordial leads indicate complete right bundle branch block (RBBB). There is a normal sinus rhythm (NSR), broad P-waves consistent with intra-atrial conduction delay and a prolonged PR interval.

The precordial leads in ECG-B again show RBBB with minor positional changes in contour. Now, however, there is an abnormal degree of left axis deviation (superior axis) in the extremity leads with small q-waves in leads I and aVL and definite r-waves in II,III, and aVF. NSR, broad P-waves and the prolonged PR interval are unchanged.

ECG-A should be interpreted as RBBB, left posterior fascicular block (LPFB) and possible conduction delay in the anterior fascicle manifested by the long PR interval. On the other hand, tracing B reveals RBBB, left anterior fascicular block (LAFB) and a long PR interval suggesting delay in the posterior fascicle. In essence, this elderly man has Stokes-Adams syncope owing to a panconduction defect including intra-atrial, probable atrioventricular and trifascicular block.[1]

Although Rosenbaum and his colleagues described the structure and function of the trifascicular, intraventricular conduction system more than a decade ago,[2] considerable controversy exists as to precise criteria for conduction defects within the system and their prognosis and management. The common or His bundle blends imperceptibly with the RBB at the level of the septal leaflet of the tricuspid valve. The right bundle branch (RBB) is a single, cylindrical fascicle that courses subendocardially along the right side of the interventricular septum and remains undivided until it terminates in a Purkinje cell network in the anterior papillary muscle of the right ventricle. On the other hand, the left bundle branch (LBB) arises nearly perpendicular to the His bundle and is located subendocardially at the junction of the right and posterior coronary cusps of the aortic valve. Main LBB is most often a short, stubby structure that divides, after a variable distance, into an anterior-superior fascicle that sweeps across the "outflow" tract of the left ventricle and terminates in the anterior papillary muscle, and a much thicker posterior-inferior fascicle that courses toward the "inflow" region of the left ventricle and approaches the base of the posterior papillary muscle. Conduction defects confined to these divisions of LBB are preferentially referred to as "fascicular blocks" rather than "hemiblocks" because of

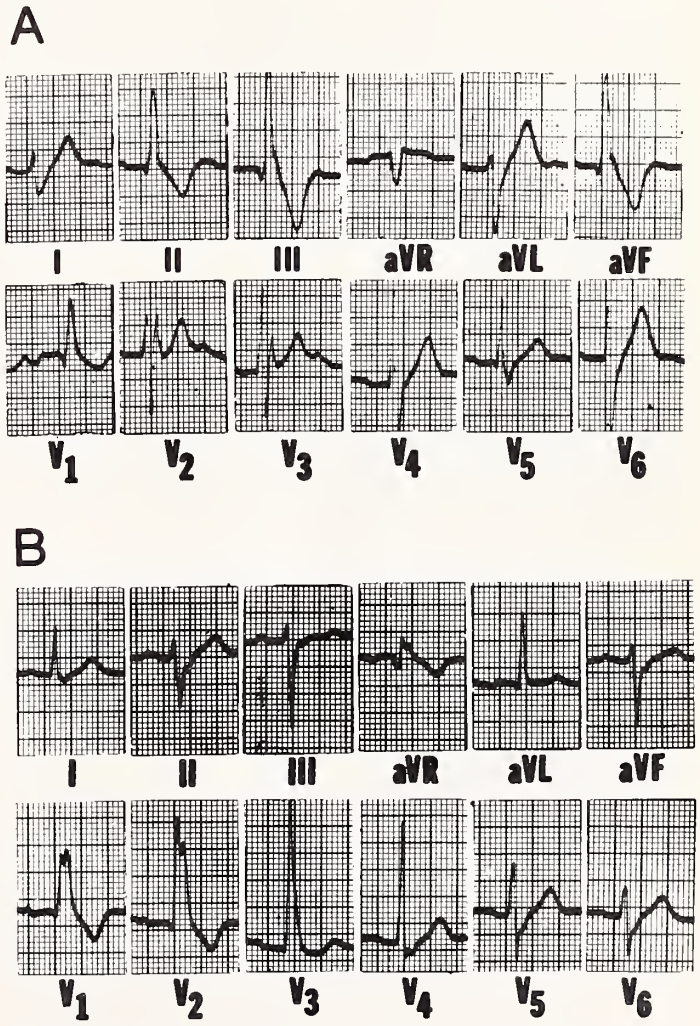

Figure 1—ECG-A shows LPFB, RBBB, NSR, a prolonged PR interval and abnormal P-waves consistent with intra-atrial block. ECG-B, obtained several days later, reveals a markedly superior axis that is diagnostic of LAFB as well as RBBB, a prolonged PR interval and intra-atrial conduction delay.

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Monofascicular Blocks

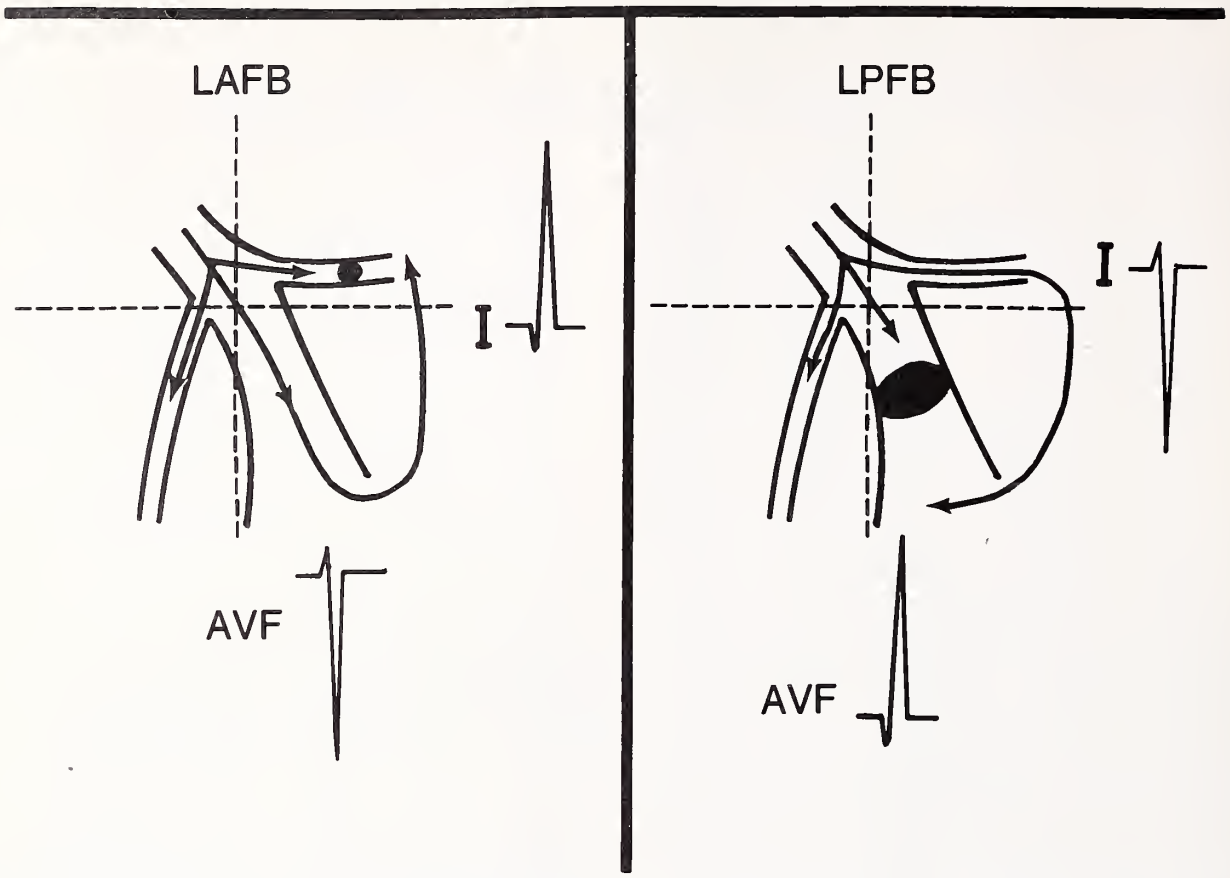

Figure 2—Schematic representation of the left monofascicular blocks. The His or common bundle trifurcates into a single RBB and a LBB that subdivides into a thicker posterior-inferior fascicle and a thinner anterior-superior fascicle. In LAFB (small, closed circle), initial QRS forces are directed inferiorly while the remainder of ventricular depolarization is oriented superiorly and written in a counterclockwise direction. This gives rise to a qR in lead I and an rS configuration in a aVF. In LPFB (large closed circle), early QRS forces are displaced to the left and superiorly, while the rest of the QRS is inscribed in a clockwise direction and is directed inferiorly and to the right. Accordingly, there is an rS contour in lead I and a qR in aVF.

the anatomical disparity in the size and mass of the fascicles. Clearly, a block in the posterior fascicle would constitute more than half-a-block, while a similar lesion in the anterior fascicle would be considerably less than half-a-block. In essence then, the intraventricular conduction system is a trifascicular structure comprising a single RBB and the two subdivisions of the LBB.

Block may be intermittent or permanent in any of these fascicles engendering characteristic changes in ventricular activation and QRS contour. In LAFB, initial QRS forces are directed inferiorly along the intact posterior-inferior ramus, while the remainder of QRS is inscribed in a counterclockwise direction and is oriented superiorly and to the left. The characteristic changes are best seen in the frontal plane: (1) initial r-waves in inferior limb leads II,III, and aVF as well as small q-waves in I and aVL; (2) deep S-waves in II,III, and aVF; (3) a superior axis, i.e., more negative than minus 45 degrees. In uncomplicated LAFB, there is little or no QRS prolongation. In LPFB, initial QRS forces are directed superiorly and to the left along the healthy anterior ramus. Main QRS forces are then written in a clockwise manner and are displaced to the right and inferiorly. These alterations provide the basic criteria for LPFB: (1) initial q-waves in II,III, and aVF as well as r-waves in leads I and aVL; (2) deep S-waves in I and aVL with tall R-waves in inferior limb leads; (3) abnormal right axis deviation, i.e. greater than 90 degrees (Figure 2). LPFB must be differentiated from right ventricular hypertrophy, lateral wall myocardial infarction and certain skeletal deformities on clinical grounds.

Bifascicular blocks occur commonly, the most frequent of which is RBBB and LAFB probably owing to the anatomic proximity of these two fascicles and their similar blood supply from the left anterior descending coronary artery.[3] RBBB with LPFB and LAFB with LPFB ("post-divisional" LBBB) are less common forms of bifascicular block.

The syndrome of constant RBBB with intermittent LAFB and LPFB, an unusual variant of trifascicular block, was originally described by Rosenbaum's and his associates.[4] They reported four patients, three of whom had Stokes-Adams seizures and one of whom had chronic Chagasic myocarditis but no historical details were available. This patient is perhaps unique; in addition to fixed RBBB and intermittent LAFB and LPFB, he also had intra-atrial block and a long PR interval that may represent intra-nodal, intra-hisian or even further intra-ventricular disease. This problem could of course, be resolved by a His bundle electrogram.

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The Behavior Modification Approach to Weight Reduction

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There has been a great deal of interest and enthusiasm over the past several years regarding the potential of behavior modification procedures for treating weight problems. Dietary, pharmacological, and the more traditional psychotherapeutic techniques have been relatively ineffective in the treatment of obesity if one uses the long-term maintenance of the weight loss as the criterion for treatment efficacy.[6,13]

RATIONALE

Rather than focusing on presumed underlying causes of the obesity problem, the various behavior modification procedures are symptom oriented and aimed at teaching the obese person how to modify his or her behavior in relation to inappropriate food consumption. Although genetic and constitutional factors may be important in the etiology of obesity, these factors cannot be changed, while inappropriate eating habits clearly have the potential of changing.

The theory behind behavior modification treatment approaches is that both normal and abnormal behaviors follow the same laws of learning, i.e., Pavlovian classical conditioning, operant or trial and error learning, and imitation learning. These learning principles, therefore, can be applied in the extinction of maladaptive behaviors and the learning of new more adaptive behavior patterns. The inappropriate food consumption patterns that are the target of treatment and modification are behaviors such as overeating, eating high caloric foods, snacking between meals, and reduced levels of physical activity. Excessive eating is viewed as a highly overlearned habit, i.e., a strongly conditioned response to numerous environmental and emotional stimuli. These cues or stimuli for food intake may include sitting in front of the television set, being with friends, feeling angry, happy, lonely, or bored.

PROCEDURES

Self-monitoring involves the process of instructing the individual to observe and record various behaviors in relation to eating. The person would keep a daily record of all instances in which food consumption occurred, as well as the type and the amount of food eaten, the time of day food intake occurred, and the environmental and emotional circumstances at that time, such as eating alone or with one's family, and/or eating in response to anger or boredom. Self-monitoring can be extremely helpful in assessing the problem behavior patterns in relation to eating for that particular individual. This technique is also effective as a means of feedback to the client about his or her progress in treatment. Self-monitoring in and of itself has been demonstrated to have a transient effectiveness in reducing food consumption,[10] and the effect is shortlived without the addition of other behavioral procedures.

Stimulus control and environmental management are procedures involving a change in the person's surroundings in order to break the learned association between particular environmental cues and food intake. The person is instructed to remove food from all places in the house except the kitchen, to lock up and make inaccessible excess foods, particularly high calorie snacks, and to eat each meal, if possible, in the same place and at the same time each day[12]. Other instructions are to place food portions directly on the plate before sitting down to eat rather than having the meal served "family style," to remove excess food from the table to avoid the temptation of taking a second helping, and to slow the pace of eating by chewing thoroughly and swallowing before taking another bite. Shopping from a grocery list to avoid impulsive purchasing of food is another aspect of situational management.

Positive reinforcement refers to the presentation of a reward following the occurrence of a specified behavior. The rewards used in behavior modification programs have included sums of money that are earned and saved for a future (nonfood) treat if a given amount of weight is lost each week or a specified habit change has occurred in a designated time period[8]. Social approval by one's spouse or family for particular behavior changes also can be very potent sources of positive reinforcement. A number of recent behavior modification programs have trained cooperative spouses in the systematic use of encouragement and social approval for appropriate eating habit changes by their partners.[1,3,5] These investigations show inconsistent results in evaluating the effectiveness of the spouse in inducing weight reduction in the partner.

Contingency contracting is a signed agreement between the therapist and the individual specifying problem behaviors to be changed and the consequences that will be applied if the behavior change does or does not occur. The contract can consist of designation of particular reinforcers that will be

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earned contingent on the occurrence of a specified weight loss each week or particular positive behavior changes in relation to eating. Further, negative events can be designated that will take place if there is a weight gain over a specific period of time or if particular behavior changes have not occurred in that time period. A dual reward-penalty contract is the most commonly used, with specific items permanently lost if particular agreed-upon behaviors do not occur[9]. However, the use of strong negative contingencies may result in the individual adhering very closely to the behavioral program while the contract is in effect, but then regaining the lost weight after the contingency condition has been removed.

Aversive conditioning is a procedure employed to develop a negative or unpleasant association to a previously neutral or positively conditioned stimulus such as carrying out a particular problem-eating behavior. Aversive techniques that have been used for weight reduction include subjecting the person to a foul smelling odor[2] or a brief electric shock[11] immediately preceding the presentation of a craved-for food. Aversive procedures have not been effective in weight loss maintenance because the individual generally engages in inappropriate eating in many different situations and overeats more than one particular food. Aversive conditioning does not change these more generalized problem-eating patterns.

Self-control strategies are relatively new to behavioral programs. These techniques are aimed at teaching persons to refrain from eating through employing specific behavioral and cognitive procedures for controlling one's behavior when there is an urge or temptation to eat. Individuals therefore learn to be more aware of and to monitor their thoughts or self-statements that typically lead to food consumption. Persons are taught to substitute more adaptive imagery or thought sequences in order to refrain from eating. For example, if repetitive snacking typically starts off with the person standing by the cupboard and saying to himself or herself, "I'll just eat this one cookie and then I won't eat any more," the person would be taught to make the following self-statement: "No, don't. Eating one cookie always leads to more no matter what I say to myself." Further, the person can be counseled to engage in distracting behaviors such as leaving the room or getting involved in some work activity as a means of refraining from giving in to the urge or temptation to eat[7].

Self-control counseling also can involve an exploration of the decision-making process and the person's commitment to change his or her behavior in relation to food consumption. It seems important to include a discussion of the issue of motivation to change one's problem behaviors in implementing any type of self-help program. Quite often persons will "shop" from one new program to another looking for an easy or magical way to lose weight, only to lose interest in a particular program when it becomes clear that they will have to work hard at changing their eating patterns in some way. Ultimately, there are no easy solutions to weight reduction and each individual must recognize that the long-term maintenance of a weight loss is dependent on one's personal behaviors and choices. It has been my experience that some persons, when confronted with the issue of commitment to change and the need for personal responsibility for their own behavior, frankly will admit that they really do not wish to change their eating habits. Thus, it can be seen that the wish to lose weight and the desire and commitment to change one's eating patterns are entirely separate issues. Therefore, it is quite important to include a discussion of the motivation to change one's problem behaviors while implementing any type of self-help program.

TREATMENT EFFICACY

The treatment outcome literature indicates that situational management and reward/penalty behavior modification programs are more effective than other currently existing programs for weight reduction except surgical intervention [4,6]. The average number of pounds lost, however, is relatively modest. The weight loss at the end of treatment averages between 7 to 16 pounds, but there frequently is an erosion of this weight loss during the followup period. Further, there is a large degree of variability among people as to the amount of weight loss, with some persons losing substantial amounts of weight and maintaining this loss over a one-year period, while other persons do not lose or even gain weight. This variability between persons is found irrespective of the specific behavioral procedures employed.

The early enthusiasm in relation to behavior modification programs may have been due in part to the fact that after Stuart's[12] extremely promising initial report, subsequent treatment outcome studies were carried out on only slightly overweight college students, with generally short followup periods of 6 to 12 weeks. The individuals, therefore, were not monitored long enough for the weight loss erosion to be noted. The current interest including self-control procedures in behavior modification, weight reduction programs seems due to the experience that no matter how well one has learned to modify one's eating patterns, a decision still has to be made at the many temptation points throughout the day regarding whether one will give in to the urge or temptation to eat at that particular moment, or decide to refrain from eating. Thus, procedures aimed at helping persons to deal with these decision points and exploring with them the issues of motivation and commitment to change one's eating behavior are currently considered of importance in implementing behavior modification programs. The goal is obviously the achievement of a long-term maintenance of the weight loss, rather than focusing primarily on short-term weight reduction.

LIFESTYLE ISSUES

Long-term changes in eating patterns would seem to depend on changes in other aspects of one's life. Behavior modification implies a permanent change in habits rather than a temporary change such as a diet to which one adheres for a short period of time and then discards when one's weight goal is reached (only to be followed by regaining the lost weight). In order effectively to maintain health weight levels, it may be necessary for the entire family to adopt lifestyle changes such as increasing physical activity levels, spending less time in front of the television set, and substituting low calorie foods for high calorie meals and snacks the family might typically eat. Expecting one person to implement a permanent change in eating patterns, while other members of the family through their behavior provide continual temptations to eat inappropriately, may be an unrealistic expectation.

REFERENCES

A list of 13 reference is available upon request from *The Journal*, MSNJ.

Stephen Wickes (1813-1889)

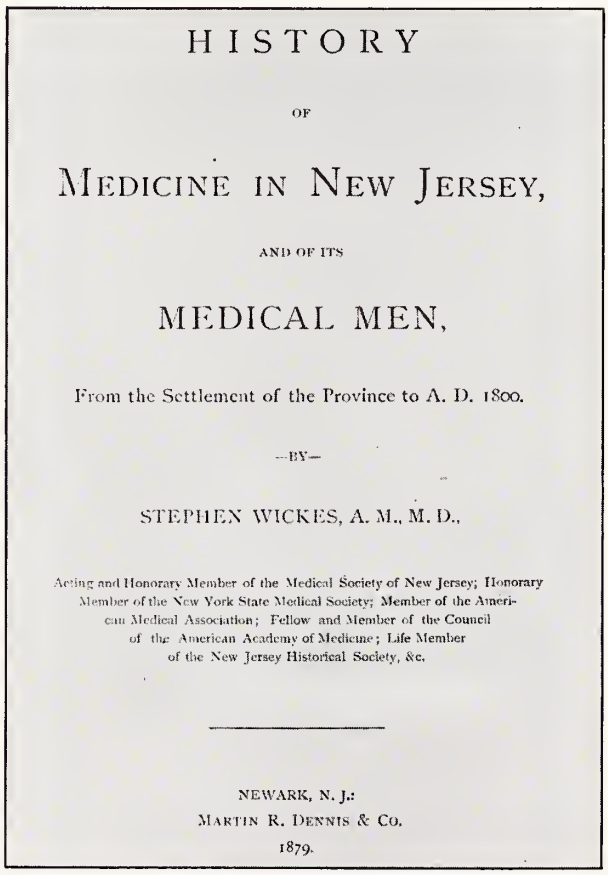
MORRIS H. SAFFRON, M.D., Passaic*

The swift flight of fame is widely accepted as inevitable, and it comes as no great surprise that the man we would honor today is virtually unknown to the present generation of our members. Yet during four important decades which included the Civil War period he labored mightily for our Society, serving at various times or even simultaneously as executive officer, editor, president and historian. Indeed were it not for the sustained zeal and effort of Stephen Wickes we would know little or nothing about our medical heritage or forebears, and many invaluable documents which he carefully preserved long since would have ceased to exist. I hope to show how fortuitous it was that Wickes decided to settle in our state and how grateful we should be to his memory.

Descended from a distinguished colonial family which in 1666 had been granted a large tract of land on Long Island, Stephen was born in the town of Jamaica on March 17, 1813. After an excellent preliminary education in the local academy, he entered Union College, Schenectady, graduating A.B. at the age of eighteen. In view of his youth and avowed interest in medicine, Stephen took a step unusual in those days—he spent an entire year in science at Rensselaer Polytechnic Institute in nearby Troy before proceeding to the Medical School of the University of Pennsylvania. There, he received his M.D. degree in 1834, the same year in which Union granted him a highly coveted master's degree.

Evidently the young man had made a very favorable impression in Troy, for shortly after setting up in practice in New York City he received an offer too tempting to resist—this was nothing less than a full partnership with his uncle, Dr. Thomas W. Blatchfield, a prominent physician of the Troy-Schenectady area, and the man who had been Stephen's first medical preceptor. In the fifteen years he was to remain up north, Wickes became a pillar of the community, an active member of many societies, a trustee of Rensselaer Polytechnic Institute and an elder of the Presbyterian Church.

Just what motivated the forty-year-old Wickes to transplant himself to New Jersey seems unclear. The death of Dr. Blatchfield, of whom Wickes has left a warm eulogy, was undoubtedly a factor. There may have been a desire for a more intellectually stimulating atmosphere, and the blandishments of his second wife, a Brooklyn girl, also must have been influential. At any rate it was our good fortune that in 1852 Wickes decided to relocate in Newark Mountains (now Orange), the beautiful residential village from which commuters had rapid access to Newark and the metropolis.



HISTORY

OF

MEDICINE IN NEW JERSEY,

AND OF ITS

MEDICAL MEN,

From the Settlement of the Province to A. D. 1800.

—BY—

STEPHEN WICKES, A. M., M. D.,

Acting and Honorary Member of the Medical Society of New Jersey; Honorary Member of the New York State Medical Society; Member of the American Medical Association; Fellow and Member of the Council of the American Academy of Medicine; Life Member of the New Jersey Historical Society, &c.

NEWARK, N. J.:
MARTIN R. DENNIS & CO.
1879.

Shortly after his arrival in New Jersy Wickes formed a strong affiliation with the New Jersey Historical Society, becoming a life member and corresponding secretary of that organization. It was in the records preserved there that he studied the early history of our Medical Society and published, in 1879, the important volume, the title page of which is reproduced above. This book, recognized as a classic, and now become quite rare, is the best history of medicine devoted to one of the thirteen original states, and for the period covered never can be superseded.

Though we already know that Wickes could never remain a passive member of any association it is quite amazing to note the ease with which this dynamic individual made his presence felt in an entirely new environment. He immediately joined the Essex District Medical Society, the largest component of the State Society, where his interest, ability and

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willingness to work soon were recognized. Indeed he must have filled some sort of vacuum, for in a short time he was invited to become a member and later the permanent chairman of the all-important Standing or Executive Committee. In view of the fact that this committee controlled all the activities of the Society in the long intervals between meetings of the Board of Trustees, the importance of this post becomes readily apparent. Wickes served on this committee from 1856-1883, relinquishing the chairmanship only to assume the presidency. Single-handed he revived the dormant annual *Transactions* (precursor of our Journal), serving as editor from 1861 to the year of his death. An admirer describes how by tactfully rewriting the papers submitted he helped to raise immeasurably the standards of the publication. He also filled the *Annual Reports* with important historical and biographical information.

Nor did he at any time neglect his own beloved profession. One colleague recalls that in his long years as attending physician at Orange Memorial Hospital, Wickes never missed a daily visit or a staff consultation. A dignified, long-bearded figure, he invariably appeared in public in a frock coat, carrying the traditional gold-headed cane. Wickes must have been a placid man, not easily aroused to anger, but when denouncing some quack he could rise to unusual heights of passion. In his own lifetime Wickes was hailed as a "benefactor of the profession," and became the recipient of many honors. Princeton granted him an honorary master's degree; our own Society made him an Honorary Member as did the Medical Society of the State of New York; he was also a Fellow of the Council of the American Academy of Medicine as well as a staunch supporter of many other societies.

As one might have surmised his own library was crammed with rare books and pamphlets which were eventually bequeathed to the New Jersey Historical Society. During the last few years of his life he devoted himself with customary assiduity to an important project, a detailed history of the Oranges, which appeared posthumously in 1894 and remains a standard work. Among the many historical and medical publications which came from his pen I mention only the presidential address of 1883. In summing up his own credo this highly religious and ethical individual referred to two favorite quotations: the first from Francis Bacon, "Every man is a debtor to his own profession;" the second from an unknown writer, "The physician who makes gold the chief end of his profession disgraces it." To all of which we can only add a heartfelt amen.

Health Choices in the Eighties

THE HONORABLE MATTHEW J. RINALDO, Washington, D.C.*

Since the time of Harry S. Truman, liberal politicians have been promoting national health programs as a way of protecting Americans against the rising cost of medical care.

The rhetoric continues in the 1980 Presidential election campaign despite growing evidence that government-sponsored health care creates demands that exhaust urban hospitals, burden nursing homes and increase health care costs far beyond levels envisaged by the architects of Medicare and Medicaid.

As urban hospitals verge on bankruptcy and close down in cities like New York, pressure groups continue to demand more, not less, health care and government subsidies in order to improve and expand medical services.

Americans already spend an average of $1,028 a year each on health care, and the average hospital bill for patient care runs to $252 a day. With health costs consuming 9.2 percent of the gross national product—up from 7.2 percent ten years ago—the public and Congress want something effective done about soaring medical costs. Yet the dichotomy persists. Some of the same people lobbying against sky-rocketing medical bills also are insisting on more tax-supported services to those who cannot afford the expensive treatment for cancer, coronary heart disease rehabilitation services and a whole range of surgical and medical assistance.

The argument over the quality of medical care and what Americans are willing and able to pay was inevitable. Inflation has brought it on more quickly than anyone had expected. Total federal spending for health will reach $53.4 billion in the 1980 fiscal budget, up almost nine percent from the year before. The new or expanded programs include $120 million for the child health assurance program; another $68 million to extend Medicaid eligibility to low-income pregnant women; $27 million to eliminate the waiting period for Medicare coverage; and $20 million for improvements in such programs as converting unnecessary hospital beds to nursing care use, community health centers, and increased funding for health maintenance organizations.

But these are modest amounts compared to the estimates of national health insurance—as much as $30 to $40 billion per year for the Kennedy proposal, for example. The political controversy over national health insurance has been intensified by inflation and a growing national debt surpassing $800 billion. Rather than confronting the thorny issue of national health insurance in 1980, Congress will plug away at something far less ambitious than a revolution in health care. Evolution seems more probable.

A more modest, but nevertheless controversial, health insurance bill to cover catastrophic illness is emerging from Senate committee hearings and may be considered in House committees. Congress also will be debating substantial changes in Medicare and Medicaid coverage, the expansion of child health care for five million more children, funding for community mental health centers, and legislation to speed the marketing of new drugs. Some of these bills, including drug law reforms, have been working their way through the Congressional mill for the past several years. Their enactment would be a major step toward redesigning the health care system to prevent chronic illness through prevention of disease and the treatment of early symptoms among the young and old.

MEDICARE GAPS

The Medicare program held tremendous promise for meeting the acute health care needs of the elderly when first enacted in 1965. Unfortunately, we have not seen the fulfillment of that promise. The high costs of medical technology and the impact of inflation on the fixed incomes of the elderly have reduced coverage to less than 40 percent of the total dollar spent on health care for the elderly. On the average, the elderly now pay more out of their own pockets for health care than they did when the Medicare law was first adopted. For many older Americans, costs are slowly closing the door to the medical attention they so desperately need.

Medicare is oriented to the coverage of acute illness. Yet the illnesses of the elderly tend to be chronic. Health maintenance, rather than a cure, most often is needed by elderly patients. Preventive medical services and more flexibility in the delivery of home health care would serve to delay the need for other more costly types of institutional care.

According to the report by the National Center for Health Statistics Research, drug costs for the elderly account for about one-fourth of all out-of-hospital drug expenditures, although the elderly represent only ten percent of the population. Furthermore, few have effective drug coverage under

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personal health insurance or any employee health plans.

The House Select Committee on Aging has been extremely interested in expanding the health care options available to the elderly, thereby reducing the demand for costly in-patient care. According to former Secretary of Health, Education and Welfare Joseph Califano, as many as 100,000 of the 700,000 people in the nation's acute care hospitals do not need to be there and could be better cared for at home.

In looking at the one million institutionalized elderly, HEW estimated that between 14 and 25 percent of them lack access to alternative methods of care. The requirements of the current law restrict the availability of in-home treatment, which better preserves the dignity and independence of the elderly.

Care for acute illness is essential, as is institutional care for those whose physical condition has deteriorated irreparably. However, the major health problem faced by the elderly is neither the acute disease nor complete deterioration of mind and body. Their problems are those of slowly progressive chronic disabilities. If we ever hope to deal with this situation, we must encourage non-institutional care before these illnesses reach the stage of hopelessness and incurability.

To cite some examples:

Medicare does not include dental protheses as a medical benefit, but pays the cost for long periods of hospitalization that result from the protein deficiency that may occur because of the inability to obtain an adequate diet. We are unwilling to pay for eyeglasses, but Medicare pays the cost of treating a hip fracture that may have been caused by a person's tripping over something he couldn't see. We are unwilling to pay for hearing aids but are willing to underwrite the cost of diagnosis and care of behavioral aberrations traceable to communication difficulties. In each case, Medicare has refused an expenditure of a few hundred dollars and has been required to pay out several thousand when the patient became hopelessly ill.

We can minimize the need for institutional care of the elderly in many cases. Evidence is available that adequate physical therapy services in institutions can reduce the incidence of debilitation and hence the need for nursing care. Yet our current funding restrictions place restraints on these services.

Screening programs for diabetes, hypertension, glaucoma, and a variety of other conditions have demonstrated that incipient disease is present in a significant number of the elderly, yet Medicare benefits are available only for the care of obvious diseases, not for programs designed to deal with general health improvements, nutrition, activity level, stress, and adjustment to change.

Insurance deductibles and co-insurance are not the answer to this problem. Evidence gathered by the House Select Committee on Aging has pointed to widespread abuses, fraud, and deception in the sale of Medigap insurance in New Jersey. Even in cases where the insurance carriers provide the services contracted for, the aged are still making out-of-pocket payments for services that should be covered by Medicare.

HMO'S FOR THE ELDERLY

In response to these problems, the House Ways and Means Committee has approved legislation that makes minor benefit improvements for Medicare and provides incentives to encourage prepaid medical plans, such as health maintenance organizations (HMOs) to recruit more elderly members. The committee agreed to send to the House a bill (H.R. 3990) to eliminate Medicare's annual limits on the number of home health care visits and somewhat liberalize coverage for certain medical services. A similar measure passed the House in 1978 but died in the Senate.

The committee also has approved H.R. 4000, which provides that care through Health Maintenance Organizations would be made more practically available to people eligible for Medicare coverage. Present Medicare regulations allow for reimbursement of care provided by HMOs at only 80 percent of the cost of identical services provided on a fee-for-service basis. H.R. 4000 would amend the Medicare program to increase the rate of reimbursement to 95 percent of the cost of care provided on a fee-for service basis. The HMO would be required to use any excess Medicare reimbursement to provide additional health care services to Medicare beneficiaries. Because HMOs offer a comprehensive package of health care services for a fixed annual charge, Medicare beneficiaries would be able to choose a wider range of care which could be provided with less paperwork than under the traditional payment system. This bill is now awaiting action in the House Interstate and Foreign Commerce Committee.

Even with these changes, we would be far from solving all the problems of the elderly. Loneliness as contemporaries die, reduction of income, lessened mobility, fear for safety, and difficulty in obtaining transportation would still plague many elderly Americans. But with improved health, some of these other problems could be handled more easily, or at least endured in a state of mind that is free of the anxieties of runaway medical bills.

In a presidential election year in which Senator Kennedy is criticizing the Carter Administration for failing to develop a comprehensive national health insurance program, the proposal to increase Medicare coverage of prepaid plans for the elderly conceivably could take President Carter off the hook.

What then is stopping it? Opponents claim that the only way the HMOs are saving money is by discouraging people from using their services. Furthermore, they warn that doctors cannot dispense good medicine on a prepaid budget, and that the potential for ripoffs is frightening. So far, however, the American Medical Association has not become an active opponent of the plan, which is picking up more support in the Senate Finance Committee. The outlook appears a great deal more favorable for enactment in 1980 than ever before. The big question is the potential cost of the program during the fourth and fifth year when it becomes fully implemented.

Indeed, the growing interest in Congress in separating Medicare from Social Security and paying for it through general tax revenues enhances the chance for passage of the new Medicare formula. The pieces of this jigsaw puzzle should start falling into place early in the 1980 session of Congress.

CATASTROPHIC HEALTH INSURANCE

Another major test of Congress's disposition to change the nation's health delivery system involves Medicaid. Deep disagreements have surfaced over how much Congress should do in 1980 to improve the medical care of the nation's poor. President Carter has proposed significant structural changes to end the dramatic differences among the states in both eligibility standards and benefits under Medicaid.

But, the administration has run head-on into Senator Russell B. Long, chairman of the powerful Senate Finance

Committee. Long has insisted that it is time to do something for the middle-income Americans who have been carrying the tax burden. Long's committee is working on a catastrophic health insurance bill which would require all employers to offer full-time employees insurance coverage for basic medical care without an upper limit on expenditures, but with a $3,500 deductible. Under the proposal, an individual or family covered by the plan would have to spend that amount each year, either out-of-pocket or through another insurance plan, before an insurance carrier began paying medical bills under the mandatory coverage for catastrophic illness. Workers earning less than $14,000 a year would have an income-related deductible, paying 25 percent of their annual income, or $3,500, whichever was less.

Among the bill's features:

—Mandated benefits: All employers would be required to offer full-time employees health insurance covering the same benefits now provided by Medicare, including physicians' fees and hospitalization, limited drugs, durable medical equipment, mental health care, home health visits and up to 100 days of nursing home care. Employers could offer more benefits than the basic package required.

—Excluded: Outpatient drugs, extended nursing home care, prenatal, maternity and infant care in the first year of life would be excluded from the minimum benefit package.

—Mandatory participation: Employee participation would be mandatory unless the employee certified that he was already covered by another employer (through a second job, a spouse's job, or a parent's job).

—Optional coverage: Self-employed individuals would not be required to buy the minimum catastrophic coverage, but would be guaranteed an opportunity to buy such coverage from an industry pool. State and local governments would have the same option for covering their employees.

—Employee share: In addition to the deductible, employees could be required to pay up to one-fourth of the costs of annual insurance premiums. However, employers could reduce or eliminate the deductible and premium payments by employees.

CARING FOR POOR CHILDREN

The House of Representatives has responded to widespread complaints that the nation's Medicaid program has failed to reach millions of poor children by approving the Child Health Assurance Program (CHAP). The bill has run into opposition in the Senate over its billion-dollar price tag and restrictions on abortion funding. The House Commerce Committee, which overwhelmingly approved the CHAP legislation by a vote of 15-5, heard a number of witnesses from health organizations, the medical profession and government agencies testify on the inadequacy of the present Medicaid coverage for poor children. It is worth reviewing some of these findings.

Nearly 11 million children in families with incomes less than 150 percent of the government poverty index are not eligible for Medicaid coverage. Even among the 12 million children who are eligible and should have access to medical care, many severe health problems exist, either undetected or untreated. More than half of the children screened for health problems are inadequately immunized. Nearly one in ten in urban areas have elevated blood lead levels, and large numbers of dental, hearing, and vision problems exist. Even under the inadequate dental screening system of the current program, about 25 percent of children have dental problems requiring care.

The benefits from preventive services and continuous care can be high in terms of promoting better health and reducing chronic medical conditions that lead to costly hospital stays, loss of family earnings, inhibited intellectual growth, and a perpetuation of welfare in many poor families. One nationwide survey indicated a drop in hospitalization of 20 percent for persons in organized care settings. Once a child has been assessed initially and given care, health status improves. Some states have experienced relatively dramatic decreases in costs of Medicaid services per child once children were screened and put under continuous care.

The positive cost-benefit relationship of prenatal care also is well-documented. Mothers with no prenatal care are three times more likely to give birth to infants with low birth weights, which is associated with almost half of all infant deaths and substantially increases the likelihood of birth defects. The prevention of mental retardation from biological causes also relates principally to good prenatal care; retardation is highly concentrated among low birth weight and premature babies. Today, the Medicaid program spends nearly $1 billion a year to provide institutional services for the mentally retarded. A decline in the need for this institutional care would result in significant program savings.

THE CHAP BILL

The Child Health Assurance Program (CHAP) was passed by the House on December 11, 1979. It would cost an estimated $2 billion a year by 1984, but its backers claim that it would succeed in cutting the long-range costs of medical care through preventive health and early diagnosis and treatment of childhood diseases.

The House bill (H.R. 4962) would replace Medicaid's much-criticized Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program with a new version that sets national performance standards and provides bonuses and higher matching rates to encourage states and individual health professionals to locate eligible children and make sure they get needed medical treatment. It would also require states to provide prenatal care for poor women.

The bill sets new, national income eligibility standards for pregnant women and children, including those in two-parent families now excluded from the program in many states, and it bars states from limiting the extent, scope and duration of a beefed-up package of mandatory medical services for eligible children.

The new standards, plus mandatory coverage for children up to age 18, would make an additional five million needy children eligible. It is estimated that about two million children would use the program, according to the Congressional Budget Office. An estimated 220,000 additional women would become eligible during pregnancy. The Senate's version, providing less benefits to fewer children and excluding pregnant women, would cost an estimated $394 million a year, plus an additional $32.4 million a year for unrelated changes in Medicaid. Although it has been favorably reported by the Senate Finance Committee, it has not been considered on the Senate floor.

States like New Jersey that have relatively high income standards and generous benefit packages would receive more federal dollars than they do now, while those that do less for children than is required by the bill would have to appropriate more funds to meet the new requirements.

DRUG LAG

The House Commerce Subcommittee on Health will be working this year on legislation to change the federal drug laws in response to complaints from manufacturers and the medical profession that the lengthy Food and Drug Administration procedures have impaired the health of Americans by creating a "drug lag."

Some controversial changes in the drug laws have already been steered through the Senate by Senator Kennedy, but the American Medical Association, the American Pharmaceutical Association and Ralph Nader's Health Research Group all have criticized the Kennedy bill.

Essentially it would give new powers to the FDA to take drugs off the market, and require monitoring of approved drugs for adverse reaction or abuses. High-risk medications would have limited distribution.

In other respects, the bill shortcuts certain approval procedures to hasten the marketing of new drugs. So-called "break-through" drugs could be prescribed before broad tests for their effectiveness are completed. However, the Senate bill (S. 1075) would mandate more drug information, including patient package information inserts in most prescription drugs.

The drug industry has long wanted swifter approval procedures reqiring less exhaustive data, like those used in European countries. Useful and important drugs are available to patients much more quickly abroad, the drug companies assert, without any harmful effects.

The House Commerce Subcommittee on Health will need time to review these complex proposals, which seem certain to receive extensive hearings before the panel, headed by Representative Henry Waxman. The anti-regulatory mood of the panel was demonstrated earlier this year when the subcommittee speedily approved a continued ban on FDA action against saccharin.

MENTAL HEALTH CONTROVERSY

Should state or community boards control federal funds for community mental health centers? That is the major bone of contention in an Administration bill to provide $347.7 million for mental health, with roughly $248 million for existing community mental health centers.

The National Council of Community Mental Health Centers, representing 700 federally funded centers around the country, objects to the fact that many states still devote a large portion of their mental health budgets to funding large state mental institutions, rather than outpatient services in community clinics. They want the states to share planning and grant approval authority with HEW, but they do not want the states to control the funds out of fear that they might bypass the community-based programs.

Advocates of state-run mental health programs are pushing for a provision giving the states the power to control the federal program's purse strings by allowing state agencies to dole out grants to clinics and other community mental health programs.

The Senate Human Resources Health Subcommittee is leaning toward a compromise that would allow the states to review all grant applications but would keep funding power within HEW. The committee wants to broaden state control over the federal program by allowing individual grant proposals to be incorporated in a statewide mental health plan. However, the states would still have to forward to HEW individual clinics' grant applications.

SUMMARY

Presidential election year politics and concerns in Congress over inflation and the budget stand in the way of passage of all these health bills in the 1980 session of Congress. But it seems clear from hearings on the bills that major changes in health care are on the way in the early 1980's.

The battle lines over national health insurance may become submerged as Congress takes a step-by-step approach toward evolving a new health care system in America based on evidence that the poor and the elderly are not obtaining adequate health care under the present system and cannot wait for Congress to agree on national health insurance.

Help for Impaired Physicians

Through its Committee on Impaired Physicians, MSNJ helps doctors who are suffering from alcoholism, other drug addiction, psychiatric disorders, or senility. The thrust of the program is rehabilitative, not punitive. The Committee is composed of physicians who have special expertise in these areas, some from personal experience. Effective treatment for these illnesses is achieved most easily when the disease is detected early and family, friends, and associates are urged to avoid misguided sympathy which enables the condition to deteriorate.

HELP US TO HELP

Call the Physicians' Confidential Assistance Line (609-896-1884). Only specially trained personnel will answer or return your call.

DOCTOR'S NOTEBOOK

Trustees' Minutes May 9, 1980

A regular meeting of the Board of Trustees was held on Friday, May 9, at the Meadowlands Hilton in Secaucus. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Prepaid Legal Service Plan . . . Noted that the State Board of Medical Examiners has interpreted MSNJ's prepaid legal service plan to assist members when called for informal hearings before that Board as an effort to provoke a confrontation. It was suggested that the President make a formal presentation at one of the meetings of the Board of Medical Examiners to explain this service which has been approved by the Board of Trustees. Presently there are 1,750 members enrolled in the plan.

Membership . . . Noted that as of May 8, 1980 there were 7,202 paid members of MSNJ (an increase of 87 over this time last year); AMA membership is 5,570.

Degree Designation on Licenses . . . Noted that the results of a poll of students at the New Jersey School of Osteopathic Medicine showed that about 50 percent of the students would prefer to use the designation "M.D." They believe "M.D." should be a generic term encompassing both the allopathic and osteopathic physicians.

Legislation . . . Approved the positions taken by the Council on Legislation on the following bills of current interest:

S-382 Russo, et al—Damages for Wrongful Death of Minors

This bill would allow computation of factors other than pecuniary loss in the wrongful death of minors with said damages to be limited to $100,000. (Current case law does not recognize such a compensable event unless the estate of the minor proved actual lost wages or income-producing activity.) If enacted, this bill could have the effect of escalating personal injury liability rates. **DISAPPROVED,** because only damages established by proof should be subject to award.

S-693 Parker—Breath and Blood Determinations—Persons Suspected of Driving Under the Influence of Alcohol or Other Intoxicating Drugs

Grants immunity to physicians who take samples or make tests at the request of police when done in a medically acceptable manner, but not forcibly and against physical resistance. **NO ACTION** (In view of our position of approval on S-398)

S-746 Hirkala—Immunity of Review Committees

Extends confidentiality to data in the possession of hospital peer review committees. **ACTIVE SUPPORT**

S-747 Hirkala—Civil Immunity of Review Committees

Extends civil immunity to hospital board members when exercising good faith in considering the appointment or dismissal of medical staff applicants. **ACTIVE SUPPORT**

S-809 Skevin—Radiology Services

Permits radiologists to bill patients for x-ray interpretations for amounts that are not covered under the person's hospital service contract. **ACTION DEFERRED,** pending further information from the Radiological Society of New Jersey. (Doctor Franzoni voted in the negative and asked to be so recorded)

S-811 Skevin—Cigarette Tax Act

Taxes cigarettes 1¢ per package to finance cancer research. **NO ACTION**

S-813 Skevin, et al—Cancer Detection

Creates within the Department of Health a cancer detection program to include detection and treatment clinics, research, and training programs in cancer detection. NOTE: Our condition is incorporated in lines 8-11 of the bill. **NO ACTION**

S-814 Skevin, et al—Cancer Control Act

Creates in the Department of Environmental Protection an Advisory Cancer Control Council which shall consist of 15 members, three of whom are ex-officio cabinet officers and 12 gubernatorial appointees. The Council shall coordinate the activities of the Departments of Health, Labor and Industry and Environmental Protection to control the release of carcinogens into the environment and the production, manufacture, sale, labeling, and use of products containing carcinogens. **NO ACTION**

S-830 Skevin—Controlled Dangerous Substances Therapeutic Research and Treatment

Creates a Therapeutic Research and Treatment program within the Department of Health that would authorize the experimental use of marihuana and other drugs under Federal protocol. MSNJ would recommend the appointment of physicians to the review board that would be established. **NO ACTION**

S-865 Orechio—Electrologists Licensing Act

Authorizes the State Board of Medical Examiners to license electrologists. An electrologist is "a person who professionally removes hair from apparently normal skin of the human body by electrical, electronic, or other technical scientific methods approved by the Board." The advisory board is to consist of three electrologists and three medical doctors, preferrably dermatologists. **ACTION DEFERRED,** pending further information from the New Jersey Dermatological Society.

S-904 Russo—Physician Advertising

Permits physicians to place their names on signs or directory posts within reasonable proximity to the building wherein their office is located. **NO ACTION**

S-943 Feldman—Cardiopulmonary Resuscitation Training (CPR)

This bill permits cardiopulmonary resuscitation training (CPR) for all high school students, under rules and regulations developed by the Department of Education in consultation with the Department of Health. Students whose parents or guardian objects on the grounds of religious beliefs would be exempt. **NO ACTION**

S-954 Scardino, et al—State Medical Examiner Act

Amends existing statutes to include as a medical examiner case the "deaths of children under three years of age where the suspected cause is sudden infant death syndrome." **APPROVED**

S-1051 Caulfield, et al—Medical Education Facilities Fund

Appropriates $2.268 million for the purpose of constructing a cancer education, research, treatment center at CMDNJ (Newark). **NO ACTION**

S-1052 Hamilton, et al—An Act Concerning Podiatrists

Redefines the terms "physician and/or surgeon" to include, unless otherwise intended, podiatrists. Does not carry with it an extension of podiatric license except that podiatrists could direct the work of "paraprofessionals" such as physiotherapists and nurses. **ACTIVE OPPOSITION,** because the bill would be confusing to the public since it represents podiatrists as something they are not, e.g., physicians and surgeons.

S-1089 Friedland, et al—Payments of Attorneys' Fees in Civil Suits

Allows the Courts to award defense costs and attorneys' fees to successful defendants in situations where the court finds a professional liability claim or counterclaim to have been frivolous or repetitious or barred by the Statute of Limitations. **ACTIVE SUPPORT**

A-485 Schwartz—Disclosure of Laboratory Tests

Requires clinical laboratories—upon written request of the patient—to supply the patient with a copy of the report that the laboratory sent to the physician. **ACTIVE SUPPORT**

A-486 Schwartz, et al—Establishment of a Hereditary Disorders Program

This bill requires the Department of Health to set up a program of assistance for New Jersey citizens who suffer from hereditary disorders such as Colley's anemia, cystic fibrosis, sickle cell anemia, galactosemia, hemophilia and Tay-Sachs disease. The program would include the development of: 1) standards for detecting hereditary disorders; 2) voluntary testing and genetic counseling services; 3) laboratory services; 4) an educational program concerning hereditary disorders; 5) curriculum guidelines (in cooperation with the Commissioner of Education) concerning the "nature, detection, prevention and treatment of hereditary disorders"; and 6) efforts (in cooperation with the Commissioner of Insurance) to eliminate "arbitrary and unreasonable discrimination against carriers or victims" of these disorders in insurance policies. **DISAPPROVED,** because there are many other hereditary disorders that should also be included in this legislation.

A-498 Weidel—Cigarette Tax

Imposes a 10¢ per pack tax on cigarettes to finance cancer research. **NO ACTION**

A-561 Kern, et al—Licensing of Nurse-Midwives

This proposal would restrict the future licensing of midwives to only those applicants that would qualify as "nurse-midwives."

Licensing would be through the State Board of Medical Examiners. Permitted acts would be: To prescribe the standards of practice of nurse-midwives under the supervision of a licensed physician. (Physical presence of the physician is not required).

(1) Such standards shall provide, but not be limited to, that nurse-midwives shall be permitted to:

(a) Assess the woman's social, medical and obstetrical history;

(b) Perform the initial physical assessment and obstetrical evaluation;

(c) Order and evaluate standard laboratory diagnostic studies or tests including but not limited to, CBC, urinalysis, serologic test for syphilis, blood type and Rh factor, sickledex, rubella screening, papanicolaou smear, G.C. culture, T.B. screening, pregnancy test, PPD, anemia workup, glucose tolerance test, thyroid profile, fetal status, chest x-ray, EKG, Rh antibody, cervical culture, throat culture, placental culture, nitrazine paper test for diagnosis of rupture of membranes, and such other laboratory diagnostic studies or tests as determined by the committee;

(d) Order nonprescription medication;

(e) Order prescription medication in accordance with approved orders of a licensed physician or upon the consultation and written prescription of a licensed physician;

(f) Provide counseling and teaching appropriate to the needs of the woman, newborn and family;

(g) Refer the woman to appropriate health and social agencies as indicated;

(h) Perform episiotomies and repair a perineal, vaginal or cervical laceration;

(i) Administer local or pudendal anesthesia during the performance of episiotomies and repairing lacerations;

(j) Provide family planning modalities including insertion and removal of IUDs;

(k) Practice nurse-midwifery in hospitals, medical clinics and other related health care facilities, including birthing centers; and

(l) Decide when and if a licensed physician should examine a woman who is under the nurse-midwife's management and care.

(2) Such standards shall provide, but not be limited to, that nurse-midwives shall:

(a) Practice nurse-midwifery under the supervision of and in consultation with a licensed physician who has current practice or training in obstetrics; and

(b) Immediately report or refer to a licensed physician any woman with any medical or obstetrical problems or any woman with complications or deviations from normal in childbirth. **ACTIVE OPPOSITION,** because this legislation advocates a double standard of medical care and fosters the unlicensed practice of medicine.

A-562 Kern, et al—Licensing of Midwives

Companion bill to A-561 (Technical Amendment) **ACTIVE OPPOSITION,** because existing statute and proposed regulations fully address the needs of the patients of New Jersey.

A-566 Deverin—Amends the Automobile Reparation Reform Act

Amends the Automobile Reparation Reform Act in accordance with the Legislative Study Commission Report. Calls for the creation of review boards to establish schedules of reasonable medical fees. **ACTIVE OPPOSITION,** because the Council feels that it is unnecessary for the Commissioner of Insurance to promulgate a schedule of fees; also there are existing mechanisms for evaluating the appropriateness of medical care such as PSROs.

A-602 Herman—Motor Vehicle Implied Consent

Would extend the implied consent law to include the taking of blood and urine samples for alcohol or drug determinations. Refusal to permit the sampling would carry the same penalty as refusal of the breath analysis test. **NO ACTION** (In view of our position of approval on S-398)

A-603 Herman—No Fault Auto Insurance

This bill places a $100,000 limit on medical expense benefits. Establishes an Advisory Committee to assist the Commissioner of Insurance in establishing reimbursement schedules for medical and hospital services, (the rates of the Hospital Rate Setting Commission would be used). Those convicted of driving under the influence would not be able to assert claims. The current $200 medical expense threshold would be retained for claims under $10,000. A verbal threshold would be used for claims exceeding $10,000. (Note: This could present a difficulty, since current Rules of Court do not allow specification of damages in pleadings. Apparently, the technique used in Federal cases of alleging simply that "damages exceed $10,000" would be used. **ACTIVE OPPOSITION,** because limitations placed on expense benefits, during this inflationary period, would not be reasonable. Bill is considered discriminatory and could lead to the rationing of health care.

A-607 Herman—Medicaid

Extends Medicaid eligibility to those currently not eligible if they encounter a catastrophic illness which means "any illness or injury requiring inpatient care in a hospital or skilled nursing facility, the costs of which exceed 25% of the person's annual net income in excess of the applicable categorical assistance eligibility level, whichever is less." **NO ACTION**

A-617 Schuck—Charitable Institutions

Persons serving without compensation on the boards of charitable institutions would be immune from liability for acts or omissions arising from the discharge of their duties. **NO ACTION**

A-676 Deverin, et al—Medicaid

Expands Medicaid coverage to medically needy persons who are ineligible under the current law because their incomes are too high. **NO ACTION**

A-744 Karcher—Revocation of Medical Licenses

Provides for the mandatory revocation of licenses to practice whenever the licensee has violated Federal or State narcotic drug laws. **ACTIVE OPPOSITION,** because many violations are technical in nature and do not warrant revocation of a license, but a lesser penalty. Current law allows the State Board of Medical Examiners to impose a suspension or revocation according to the gravity of the offense and is preferrable to this bill.

A-769 Deverin—Respiratory Therapist Act

Provides for the licensing and regulation of respiratory therapists and technicians under the auspices of the State Board of Medical Examiners. Provision of services other than under the direction or supervision of a physician shall be cause for revocation of licensure. **ACTIVE OPPOSITION,** Council feels that respiratory therapists and technicians should function under the supervision of physicians and should follow the rules and regulations of the hospital medical staff.

A-771 Deverin—Arrests of Apparently Intoxicated Persons

Requires police officers when making arrests of apparently intoxicated persons to examine those persons for the presence of medic-alert bracelets or other forms of identification. **APPROVED**

A-774 Deverin—Occupational Therapy Licensing Act

Creates a new class of licensed practitioners who would function independently and would be permitted to perform such services as the design, fabrication, and application of splints; sensorimotor activities; the use of specifically designed crafts, guidance in the selection and use of adaptive equipment, therapeutic activities to enhance functional performance; prevocational evaluation and training, and consultation concerning the adoption of physical environments for the handicapped. The State Board of Medical Examiners will exercise jurisdiction. **DISAPPROVED,** because this bill lacks the proper physician direction.

A-819 Bassano, et al—Controlled Dangerous Substances Research

Creates a research program within the State Department of Health. Patients not responding to conventional therapy will be allowed into the program. Drugs currently on the Federal Drug Administration experimental list, i.e., marihuana, etc. will be utilized under Federal guidelines. The MSNJ will be given an active role, i.e., making recommendations to the Commissioner of Health for appointment to the Therapeutic Research and Treatment Qualification Review Board. **NO ACTION**

A-859 Curran, et al—Death With Dignity Act

Would permit adults to direct that in the event of a terminal illness no extraordinary maintenance medical treatment is to be used to prolong life. **APPROVED**

A-878 Hurley, et al—Blood Collection and Replacement

All blood banks would be required to engage in reciprocal exchange programs without regard to geographical location or organizational affiliation. The assessment of non-replacement fees is prohibited. The New Jersey Public Health Council shall regulate the system. **DISAPPROVED WITH ACTIVE OPPOSITION IF THE BILL MOVES,** because MSNJ House of Delegates' policy mandates pluralism in the recruitment of donors and this bill does not have such a provision.

A-882 Hurley, et al—Withholding or Withdrawing of Life-Sustaining Procedures in Event of Terminal Illness

Empowers adults to execute a statutory form of directive to their physicians providing for the withholding or withdrawing of life-sustaining procedures during a terminal illness. The directive would be valid for five years and provides immunity for physicians and other providers complying with such a directive. "Life sustaining" means a modality or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which would serve only to artificially prolong the moment of death where in the judgment of the attending physician death is imminent whether or not such procedures are utilized. It does not include "the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain." **APPROVED**

A-887 Hurley, et al—Motor Vehicles

Provides for implied consent to the taking of blood and urine samples for chemical analysis to determine drug content. Samples may not be taken forcibly and against the physical resistance of the person being arrested. **APPROVED**

A-923 Herman—Prescription Drugs

Amends existing law to permit patients to possess a ten days' supply of a controlled dangerous substance in a container other than the original provided the patient carries with him a writing provided by his physician detailing—the name and address of the dispensing practitioner, the prescription record identification number, the name, address and registration number of the prescriber, the name of the substance, and the directions for its use. **APPROVED**

A-928 Stockman, et al—An Act Prohibiting Demands for Payment as a Condition Precedent for Completion of Insurance Forms

Prohibits physicians from demanding payment from a patient for services rendered prior to completion of a medical claim form in connection with an insurance policy or plan. **ACTION DEFERRED,** pending further information from the New Jersey Society of Anesthesiologists and other specialty societies that may be involved.

A-962 Orechio—Misrepresentation of Medical Reports

Makes it a crime of the third degree for a physician to intentionally falsify a medical report which is used in negotiations, administrative or judicial proceedings. **(CURRENT LAW)**

A-966 Stewart—Radiation Protection Act

Calls for the Departments of Health, Energy, Transportation, Environmental Protection and the State Police to develop a Radiation Emergency Response Plan. **(CURRENT LAW)**

A-1031 Fortunato—Special Hospitals Emergency Services

All special hospitals would be required to provide full time emergency services coverage. **ACTIVE OPPOSITION,** because the context of the bill is not clearly defined i.e. (What is meant by resident physician?, etc.) plus the cost implication would defeat the purpose of the bill. There are twenty-two hospitals licensed as "special hospitals" within the State that have arrangements for a physician to be on call at all times, but they are not physically present.

A-1140 Schuck—Medical Education Facilities Fund

Appropriates $9 million for CMDNJ (Camden) land acquisition and construction. **(CURRENT LAW)**

A-1155 Lesniak—Parental Notification Prior to the Performance of an Abortion

Requires parental notice prior to the performance of an elective abortion on an unemancipated minor. **ACTIVE OPPOSITION,** because this bill is an inconsistency of existing law e.g., a pregnant woman has already been declared an emancipated minor under Title IX of the New Jersey Statutes.

A-1184 Orechio—Eye and Ear Examinations of School Children

Mandates boards of education to employ one or more optometrists to be known as the "school vision examiners" and one or more physicians to be known as "school hearing examiners." (The hearing examiners may also be the medical inspectors). **ACTION DEFERRED,** pending further information from the Academy of Ophthalmology and Otolaryngology.

A-1205 Brown—Medical Education Facilities Fund

Appropriates $2.268 million for the purpose of constructing a cancer education, research and treatment center at CMDNJ (Newark). **NO ACTION**

A-1247 Orechio—An Act Prohibiting Certain Physicians' Charges

Makes it unlawful for a physician, rendering medical services, to charge certain persons more than their health insurance contracts allow. **ACTIVE OPPOSITION,** because the bill is too all-inclusive, it is unclear, and puts a burden on the physician of determining insurance coverages.

Reportable Diseases . . . Approved the following recommendation from the Council on Public Health concerning revision of Chapter II of the New Jersey State Sanitary Code—Reportable Diseases:

That the Medical Society of New Jersey endorse the proposed revisions to Chapter II —Reportable Diseases, New Jersey State Sanitary Code, dated March 10, 1980, with the addition of the following diseases to those which must be reported: Guillain-Barré Syndrome, Kawasaki Disease, and Reye's Syndrome.

Medicaid Audits . . . Directed that the provisions contained in the Bureau of Medical Care Surveillance's Manual of Operation concerning Medicaid audits be published in *The Journal* and the *Membership Newsletter* for the information of the membership. (See Page 541 this issue.)

Note: As directed at the March meeting of the Board of Trustees, Legal Counsel contacted the Division of Medical Assistance and Health Services concerning the establishment of a protocol for those assigned to conduct Medicaid investigations and interviews that will foster a positive environment. Legal Counsel believes that the statements in the Manual of Operation clearly establish the type of positive environment the Society desires and should minimize adverse situations; however, this deals with human beings in a potential ego-damaging situation and personality conflicts and unpleasantness are inevitable. Counsel believes that the Board of Trustees cannot improve the Manual's format.

Executive Sessions of the State Board of Medical Examiners . . . Received a response from the Executive Secretary of the State Board of Medical Examiners to MSNJ's request for an explanation of the exclusion of MSNJ representatives at executive sessions of the State Board while other non-Board, non-staff attendees have remained, indicating that this information is inaccurate, and that there is no preferential treatment rendered to unauthorized persons at Medical Board meetings. All are requested to leave the room when the Board goes into closed session; those who remain are Board members, staff, and two chiropractic assistants, appointed by the Governor in accordance with New Jersey Statutes and authorized by the Attorney General to stay in the closed sessions. This explanation prompted a rebuttal questioning the protocol since the applicable New Jersey Statute calls for chiropractic assistance relevant to certain sections of the Statutes and not to the general regulation of those licensed to practice medicine and surgery, or disciplinary actions involving those medical licensees. A formal presentation on this issue will be made to the State Board of Medical Examiners and no action will be taken by MSNJ until a reply is received from the State Board.

Blue Shield Regulations . . . Received as informative the following report from the Executive Committee concerning Resolution #12 (1979) relative to Blue Shield Regulations:

- The purpose of Blue Shield is to provide "service benefits" for low and middle income subscribers. When patients are over income, service benefits do not apply and the claims are honored by the major medical carriers.

• The following statistics were given regarding the number of persons eligible for "service benefits":

Series	Persons
500	47,560
750	266,545
14/20	111,470
	425,575

(Total enrollment is 3,775,000 persons)

The "service benefit" eligible figures are computed from 1977 State of New Jersey income statistics. There would be fewer eligible at the present time as salaries have increased since 1977, but the service benefit ceiling has remained unchanged.

• Participating physicians contribute to cost containment by agreeing to accept the Plan's payment as payment in full for eligible "service benefit" subscribers. By reason of this contribution to cost containment, Blue Shield is changing its procedures, so that participating physicians will be paid directly for eligible Blue Cross/Blue Shield major medical payments for over-income subscribers.

• New Jersey Blue Shield agreed to consider Mr. Maressa's suggestion that a special participating physician agreement be developed under which the physician would consent to forego the deductible and co-payment, so that the eligible major medical payment would be made directly to the physician for under-income subscribers. (This would preserve the "service benefit" principle.)

• Blue Shield agreed to conduct studies to determine the amount of subsidization conducted via participating physicians and the various Plan programs.

• It was agreed that the Executive Committee and Plan officers will meet on a biannual basis to exchange views. (In order to avoid problems with the Federal Trade Commission, the invitation to meet will be extended by Blue Shield.)

Note: The understanding is that the Board will be notified of the results of the studies agreed to be undertaken by Blue Shield and that MSNJ's Executive Committee and representatives of Blue Shield will meet twice a year.

Medicaid Survey by Public Advocate . . . Directed that the general issue raised by the Ocean County Medical Society concerning a summary report of a Medicaid survey conducted by the State Department of the Public Advocate to determine the adequacy of primary medical care in Ocean County be referred to the Council on Medical Services for investigation.

. . . Directed that the Committee on Medicaid consider the advisability of conducting a survey in each county to determine the number of physicians treating/not treating Medicaid patients, and the effect on the medical care of these patients.

Note: It was the consensus of the Board that medical care of Medicaid patients is a concern not reserved to Ocean County alone. It was suggested that if a response were to be made to the Public Advocate, there would be justification in stating that the problem of medical care for Medicaid patients had been promoted by the design of the Medicaid program.

James S. Todd, M.D. . . . Rose in a vote of appreciation to James S. Todd, M.D., for a commendable job during his three terms on the Board of Trustees, five years of which he served as Chairman.

Medicaid Audit Protocol

The following statements are taken from the Bureau of Medical Care Surveillance Manual of Operation and clearly provide for the type of positive environment the Medical Society seeks. (See "Medicaid Audits" in the May 9, 1980 Board of Trustees' minutes, page 540, this issue.)

"Interviews are highly sensitive because of the unique role of the Bureau of Medical Care Surveillance. When interviewing providers, care should be taken to promote positive relationships. Such interviews should be low key, relaxed, and held in a helpful and informal manner whenever possible. Special provider problems should be given consideration and referrals to Medicaid contractors or local Medical Assistance Units initiated as appropriate. In this regard, the presence and expertise of Medicaid consultants usually are helpful.

"When indicated, it is desirable to schedule appointments in advance of provider interviews. At such times a brief explanation of the general purpose of the interview should be given, e.g.: 'a routine audit to verify that your records are complete.' An effort should be made to schedule appointments with providers at the provider's convenience; that is, when the doctor-patient relationship will not be disrupted. An out-of-the-way room in the provider's office suite should be requested for review of patient records."

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

GRANT FOR OUTPATIENT CARE

A pioneering program to enhance continuous, personalized care in outpatient clinics, funded by an $800,000 grant from the Robert Wood Johnson Foundation, has been initiated at the CMDNJ-College Hospital, Newark. The grant, one of only 15 awarded to teaching hospitals throughout the country, will assist in converting CMDNJ-College Hospital's ambulatory care services to a physician group-practice system, in which patients can receive comprehensive primary care and specialty referrals under the supervision of one physician.

Since a continuing relationship between patient and physician already was being stressed at the hospital, the College served as the national model for the new program. Under the hospital's FIRM system, which was instituted in 1975, outpatients receive continuous care by the same physician who administers an overall plan of care. The grant project will help both the school and the hospital further to refine this system with additional services and manpower. Specifically, the grant will provide for expanded residency programs in primary care and attract additional physicians to the attending staff. Clinical hours for the group practice will be increased. A 24-hour telephone for patients to call when in need of medical advice will be provided.

David E. Rogers, M.D., president of the Robert Wood Johnson Foundation, reports that the grant program was established to assist teaching hospitals, mainly in urban areas, which increasingly have taken on the role of "family physicians" to their immediate communities over the past decade. He said that one-fourth of all visits to physicians in the United States last year took place in outpatient clinics, and that teaching hospitals—which make up only five percent of all health care institutions—were the site of 25 percent of these visits.

With the CMDNJ-New Jersey Medical School as a pioneer in the concept of the teaching hospital as "family physician," the new program only serves to underline the College's self-determined role. When the medical school moved to Newark in 1967, it entered into a social contract with the community to supplement the local health care system, and to

help in alleviating some of the city's most pressing health needs. What was considered at that time to be a radical course of action for a teaching institution has since become the rule for many medical schools and the College's guiding principle through the State.

The College's Health Services in Newark have been developed over the last decade with a dual purpose: to provide high-quality primary care to the immediate community and to develop sophisticated tertiary care specialties which serve the entire State through physician referrals. Faculty, housestaff and students at the Newark units have been recruited with an eye toward their interest in community service as well as academic credentials.

The new project further will enhance the medical school's efforts on behalf of the community and provide a workable model for similar health care programs developing under CMDNJ auspices in New Brunswick and Camden. The program will be directed by Carroll M. Leevy, M.D., professor and chairman of medicine at CMDNJ-New Jersey Medical School and chief of medicine at CMDNJ-College Hospital. Carter Marshall, M.D., professor of medicine and director of primary care at the medical school, will serve as the program's medical director.

RADIOFREQUENCY RHYZOTOMY

In another CMDNJ-College Hospital development, a new neurosurgical procedure involving a special x-ray technique is employed by neurosurgeons there to enable the spinal cord injury patient to lead a more normal life. Called percutaneous radiofrequency rhyzotomy, the procedure is used for the treatment of severe spasms and spasticity as well as for treating patients suffering pains caused by trigeminal neuralgia. The procedure, which has been performed with relative frequency over the past few months, employs a fluoroscope to locate the nerve roots causing the spasm or pain and destroys the injured ones selectively through a radiofrequency probe. No anesthesia is required and it is possible to evaluate the results immediately. More important to the patient, the procedure produces an immediate effect.

As dramatic as the rhizotomy technique is, it represents only one of the many life-restoring procedures carried out routinely by neurosurgeons at CMDNJ-College Hospital, headed by Abbott J. Krieger, M.D., chief of the neurosurgery section. His team includes Otakar R. Hubschmann, M.D., and Roger W. Countee, M.D., assistant and associate professors, respectively, of neurosurgery at CMDNJ-New Jersey Medical School.

In 1979, the first 11 months of the new hospital, trauma accounted for two-thirds of neurosurgical admissions, with elective procedures, such as the rhizotomies, making up the other one-third. During that time, there were no instances of mortality associated with the rhizotomy procedure, or with surgery for aneurysms, arteriovenous malformations, carotid endarterectomy, transphenoidal hypophysectomy, shunt surgery or cranioplasty. This record compares favorably with other university hospitals.

As an example of the hospital's teamwork, an operating room there provided the setting recently of an assemblage of a plastic surgeon, an oral surgeon, a neurosurgeon and an opthalmologist. This team collaborated in repairing and reconstructing extensive damage to the skull, brain, the dura and the facial bones of a young woman who was involved in an auto accident.

Dr. Krieger and his team of neurosurgeons are also expert micro-neurosurgeons. Their operating procedures are often videotaped to teach students and other neurosurgeons the techniques on the use of the microscope during surgery. Special tapes also have been prepared to teach nurses and allied health personnel the proper procedures for setting up the microscope for surgery as well as the correct care and assembly of the microscope itself.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

The hospital rate-setting program of the New Jersey Department of Health continues to attract attention. A *New York Times* editorial of May 13, 1980 said that the technique could encourage economy. If a hospital knows in advance what it will be paid for a particular problem (with a specific DRG), there will be an incentive to avoid unnecessary tests and overlong stays. The method can influence the decisions of doctors and the demands of patients. The experiment points the way to a financing system that will, for a change, reward thrift.[1] To call it an experiment is proper, since no predictions on accuracy can be made.

The potential effects of the DRG program on other projects are causing some concern. Relationships with the eight PSROs are being developed. Utilization regulations will be part of the DRG system. The paying agencies will be responsible for utilization, and it is expected that PSROs will be involved in concurrent monitoring. Factors involving quality assessment are to be referred to the appropriate PSRO, which will confer with the involved hospitals and the Rate-Setting Commission. Details may evolve in ways not anticipated as of this writing. There may be bodies *other than* PSROs involved. What will be the effect on the use of PSRO criteria? It is possible that statewide criteria may be developed. If it appears that the DRG system may be more cost effective, DRG might be substituted for PSROs in this State. Our colleagues who desire the demise of PSROs may be more unhappy with other reviewing bodies. Dr. Claude E. Welch, in an editorial in *Archives of Surgery,* suggests that PSROs be supported as: ". . . . . the more important and perhaps the *last available* supervisory organization that is composed entirely of physicians . . . ."[2] (emphasis added).

The effect of DRG payment on the HMO movement is also difficult to predict. HMOs will pay the same amount for a hospital stay as insurance carriers, despite having fewer days of care per thousand subscribers than conventional payers. DRG payment may diminish the competitive edge of HMOs.

It is important to remember that DRG information may be used for planning purposes, reorganization, certificate of need, training program regulation, and so on. The accuracy of the data will need to be peerless. Monitoring will go on at many levels. The New Jersey Hospital Association and MSNJ will cooperate in watching how the experiment evolves.

There was much discussion in the House of Delegates in May on DRG regulations and S-446. S-446 is the law, passed in June of 1978, which established the Rate-Setting Commission and authorized the prospective reimbursement for all hospitalized patients, including the indigent. The law does not mention DRG. Regulations are developed to implement laws. The Health Care Administration Board approves initial publication of proposed regulations in the *New Jersey Register.* There is

usually a twenty-day comment period, after which the "regs" are brought back to the HCAB for final approval. Public hearings are held when indicated by the importance of the issue or the amount of interest. The *New Jersey Register* is becoming one of the best-selling periodicals in the State. Interested physicians should review *NJR* regularly. Your hospital administrator receives the monthly issues; your county medical society also should subscribe. It is necessary, in this bureaucratic world, that physicians learn not only the rules, but how they are developed.

The phaseout of HEW should be noted. In May, the Department of Education was carved out, leaving Patricia Harris as Secretary of Health and Human Services (HHS, or H_2S). HEW began in 1953 with 35,000 employees and a budget of $7 billion. At the time of change, there were 148,000 workers and a mere $200 billion on the books, all cost effective, of course.

[1]*New York Times:* Regarding hospital thrift (editorial). May 13, 1980.
[2]Welch CE: Cost containment (editorial). *Arch Surg* 115:571, (May) 1980.

Morris H. Saffron Lectureship on History of Medicine*

(The following address of the President of the Academy of Medicine of New Jersey, Adam Wychulis, M.D., was read by the President-Elect, William Minogue, M.D.)

As President of the Academy, let me say what a pleasure it is to welcome so many of you to our new home which we share with our venerable fellow institution, the Medical Society of New Jersey. Many of you will recall that the New Jersey Society was founded in 1766—that is to say ten years before our own Revolution—and has the honor of being the oldest Medical Society in this country.

*The First Annual Morris H. Saffron Lectureship on the History of Medicine was delivered May 7, 1980 at the Medical Society of New Jersey headquarters building, 2 Princess Road, Lawrenceville, New Jersey, where the Academy of Medicine of New Jersey, sponsor of the program is housed. The first lecturer, Dr. Genevieve Miller of Johns Hopkins University, is an eminent authority on the history of smallpox inoculation, and President of the American Association for the History of Medicine.

But our primary purpose in meeting here this afternoon is to pay our respects to an individual who has done all that a single person could do to stimulate interest in medical history in general, and especially as it relates to our own State of New Jersey.

A native of Passaic, Morris Saffron was graduated from Columbia College and the University of Maryland Medical School. It was while attending the latter that he developed a lifelong interest in medical history. Aside from practicing his specialty of dermatology for over forty years, Dr. Saffron's interests included the arts, music, and travel, but above all he loved to collect books. Morris tells me that although he never kept an accurate account he may well have owned during his lifetime as many as 10,000 books, the great majority of which already have been dispersed to various institutions.

When he joined our Academy in the early forties, it was natural that he soon became chairman of the Library Committee, a position he retained for many years. Later he served one year as President and editor of the *Bulletin* for almost a decade.

One of Dr. Saffron's great dreams was that New Jersey eventually should have a medical school of its own, and that he should be the one to lecture there on the history of medicine. Having spent five years on active duty during World War II, he returned not only to private practice, but also to the history class rooms at Columbia. In 1950 he received a master's in American history, and after many years of midnight toil he eventually was granted the coveted Ph.D., the oldest person in the history of the University to obtain this earned degree. In 1958 when Seton Hall finally did open its doors in Jersey City, Dr. Saffron was named Professor of Medical History, and gave the first formal course of lectures on this subject to be delivered on New Jersey soil. Since then he has continued to lecture in both branches of the present College of Medicine and Dentistry.

When in 1970 because of limitations of space the Academy found itself obliged to divest itself of its library and museum we naturally sought the advice of Dr. Saffron. Although he was a very reluctant Solomon indeed, he finally agreed to divide the baby, giving the books to Newark, the museum to Rutgers. A plaque in the History of Medicine Room of the Library on the Newark campus bears tribute to Dr. Saffron's efforts in this connection.

Dr. Saffron is the author of several books, a collaborator in others, and has published many articles on medical history. His latest work on John Cochran gives the story of a Revolutionary surgeon, who was also one of the founders and an early President of the New Jersey Medical Society. Since his retirement from practice two years ago, Morris has been engaged actively on still another book.

Finally a word on the lectureship which we institute today. Credit for its suggestion must go to Dr. Leo Siegel who received the active support of Dr. Victor Parsonnet, both men being former Presidents of the Academy. A modest funding was provided by friends of Dr. Saffron, and we would welcome additional support. It is our fond hope that this lecture will become the first of many such festive and cultural occasions and that Morris will be with us for many years to enjoy this single fruit of his much appreciated labors.

Fifty Years of Group Medical Practice

The Summit Medical Group, the oldest and largest group practice in the tri-state area of New Jersey, New York and Connecticut, began its fiftieth year of continuous patient service in May.

In observing the Golden Anniversary, Group co-founder Dr. Maynard G. Bensley, 91, said, "Group practice is one of the most effective means of delivering medical service to the American people."

Dr. Bensley and Dr. William H. Lawrence introduced the concept of team medicine to New Jersey in 1919, and eleven years later they officially established group practice with six other physician-specialists. During 1979 Summit Medical Group's 43 physician-specialists treated more than 150,000 patients.

Among the first to be accredited by the American Group Practice Association, the Summit Medical Group pioneered medical auditing within its own organization and at nearby Overlook Hospital in the early 1960's. All Group practitioners have privileges at the hospital (which also was founded by Dr. Lawrence in 1905), and through this affiliation they are involved actively in educating 92 residents and fellows from Columbia University's College of Physicians and Surgeons.

Pooling Health Care Data in New Jersey

Donald P. Burt, M.D.*

New Jersey PSROs should pool their health care data. Control by physicians is essential. Other health data collectors could join a common pool, with assured individual confidentiality. The value to the medical profession and the direction in which these studies should go is discussed.

New Jersey Professional Standards Review Organizations (PSROs) are in a unique position to perform health care studies because of a collection system through which the eight PSRO areas could pool their data to get more meaningful results. The potential for pinpointing problem areas in health care delivery in New Jersey, helping hospitals to provide patient care more efficiently, and improving and updating audit activities in individual hospitals is an exciting prospect for the immediate future. Such studies are in their infant stages and much is yet to be collected and evaluated before valid conclusions can be reached. The aim of New Jersey PSROs always will be to utilize such data to help practicing physicians; evaluation of their performance offers the potential for the best possible care to patients. We believe no physician objects to such a premise and indeed openly will welcome the opportunity.

As they now operate, PSROs are collecting hospital discharge data from which some information on health care delivery can be obtained. An additional large capability for in-depth study is available via the utilization review and audit systems which PSROs are supervising for Medicare and Medicaid patients. Through consultations with private computer firms, the PSROs may initiate many investigative pathways utilizing these systems.

The bugaboo of confidentiality has pretty much been laid to rest. Persons may have access to computer data only by entering into it a prearranged code, which is known only to one or two chosen persons and is regularly changed. This prevents even the computer company from obtaining meaningful information. All sensitive identifiers are, of course, previously coded before computer entry. Confidentiality is being built into the computer system quite readily. All that remains is to educate some physician doubters that this is indeed so. You can be sure our PSRO physician directors are keeping a close control over this aspect.

METHODS OF ASSESSING QUALITY OF CARE

Quality review always has involved mortality and morbidity statistics, and complication rates; lately process audits have been used. Retrospective audits have their value, but they are limited in providing desired information to the practitioners. More recent studies relating quality of care to outcome also have value and limitations.[1-5] A recent report evaluating concurrent quality assurance (CQA) by monitoring quality while patients still are hospitalized has given additional clues to the solution of the problem of evaluating the quality of care.[6] In concurrent auditing (done while patients are hospitalized) the PIPSRO** study mentioned[6] indicates that process and treatment criteria are in the mselves of limited value since adherence to them in 24 experimental hospitals compared with 26 control hospitals had little to do with the outcome when pooled data for seven diagnoses were compared.[6] There was an indication that setting of criteria for unacceptable forms of treatment might be useful, and that looking at specific diagnoses had some definite potential. The overall tone of this study bodes good for the way medicine generally is practiced.

DIRECTIONS FOR PRESENT AND FUTURE

Any study by New Jersey PSROs would do well, for the present, to focus on more easily interpreted and more statistically significant parameters, such as unacceptable treatments. Diagnoses should be chosen which are meaningful and important because of their high prevalence, high morbidity or mortality, and their positive treatment modalities. Myocardial infarction, bacterial infections, complications of gastrointestinal ulcers, and cancer chemotherapy are some that come to mind.

The necessity for performing certain hospital procedures can be more meaningfully evaluated with pooled data. At first these should be limited to those about which there is some definite valid controversy as surfaced by already completed studies. In this category are prelabor[8,9], hysterectomies[10] and T and A's.[11]

Data relating to unnecessary length of stay (LOS) and thus directly to cost can be of great value to physicians by pointing to the true (often non-medical) reasons for prolonged stay. An example would be the number of days that patients insured by Medicare and Medicaid utilize acute care hospital beds while waiting for nursing home beds. Many of our PSROs are in the process of collecting these data now. Other, shorter, unnecessary stays can be studied and corrected, e.g., (waiting days for elective surgery, waiting days for laboratory tests, and so on). Elimination of such delays will benefit both the patient and the hospital.

A study of unnecessary admissions would undoubtedly demonstrate the cost of a rule that requires three days in hospital before a Medicare patient can be admitted to a nursing home. One might evaluate the admission time period, preadmission testing, outpatient procedures, and one-day admissions.

The eight New Jersey PSROs are diverse, encompassing large cities such as Newark and Camden, heavy industrial areas, crowded suburbs, vacation lakes and hills, large areas of farmland, and a busy coastline divided between shipping and resorts. The number of hospitals in each area ranges from seven to 23 and vary as to size, teaching capacity and type of population served. Statistics pertaining to these and other variables would be of great interest.

On the other hand, no PSRO area is large enough to satisfy the statistician's goal of valid conclusions. Thus there is a need for statewide pooling of data. Information pertinent to the local health needs of each area, as well as data pertinent to statewide problems would be very useful. The potential benefit to individual hospitals and health care agencies is great. Other groups such as Blue Cross and Medicaid are collecting data on health delivery in New Jersey and there is no reason why all of us should not pool data on common problems. We believe a multifaceted statewide pool of health care data with qualified private computer company services can be of great value in the common search for maintaining and improving quality care at the most reasonable cost. Confidentiality for each of the participants most certainly can be assured.

PHYSICIAN CONTROL

Much of the criteria for studying health care must be written by physi-

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cians. Choosing topics, evaluating outcomes and setting goals in these areas are physicians' jobs. Local committees and statewide committees, led by interested physicians, are essential and valuable to such an undertaking. PSRO members, all practicing physicians, are ideally suited to form such committees and would continue to ensure control at the grass-roots level. They would set criteria and otherwise provide the necessary professional leadership to a statewide data committee which has representation from all interested parties. The data committee would include the Hospital Association, the State Department of Human Services, private insurers, the "Blues," the Department of Health DRG program, the HSAs, but would not exclude other interested parties.

COST

The cost of such a venture would have to be borne by all the parties involved on an equitable basis. For example, fair share payment to a private computer consultant firm would depend upon the individual time used by each participant for services delivered. The U.S. Department of HEW through the PSROs and the State of New Jersey via Medicaid and DRG programs, may be heavily involved initially. Their cost experts would have to evaluate the potential dollar benefits involved. Private insurers and private industry might help to defray costs if they could see potential savings to themselves. New Jersey PSROs now are doing hospital utilization review for some insurance companies and for some HMOs. They can offer industrial companies a similar service in the belief that pooled health care data may save dollars. Hospital discharge data may be combined with political and cost data, for example. The result could be more efficient and more cost effective health care delivery. This kind of information could be tailored for use by physicians, hospitals, State DRG, Medicaid programs, and insurance companies.

SUMMARY

By virtue of their data collection system, New Jersey Professional Standards Review Organizations (PSRO) are in a unique position to perform health care studies. Statistics can be pooled and data analyzed through consultation with a private computer firm working confidentially for the PSROs. Physician privacy can be maintained carefully.

Past and present methods used in assessing quality of medical care are reviewed. The lessons learned point to several ways we can begin utilizing data in New Jersey for the benefit of communities, hospitals, health service agencies and physicians. Pooling of data with other health data collection agencies, if protective of confidentiality, could be of great value.

In order to keep proper perspective, provide expert guidance and assure confidentiality, physicians must continue to be the leadership in this endeavor.

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Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Mohammed Mushtaque, M.D., 183-11 Hillside Ave., Apt. 11-K, Jamaica, NY 11432. Dow (Pakistan) 1975. Board eligible. Group, solo, or institutional. Available.

Narciso J. Samuy, M.D., 1180 East and West Road West, West Seneca, NY 14224. Santo Tomas (Philippines) 1970. Board eligible. Group or partnership. Available.

Peter J. Arches, M.D., 150 Fayette Avenue, Apt. 2-H, Staten Island, NY 10305. University of East (Philippines) 1969. Board eligible. Group practice. Available.

DERMATOLOGY—Ellen Blank, M.D., 1675 York Avenue, New York, NY 10028. Mt. Sinai 1975. Board certified. Any type practice. Available.

Karen Kade, M.D., 38 Fidelity Court, Carrboro, NC 27510. Albert Einstein 1976. Board eligible. Multi-specialty group. Available August 1980.

FAMILY PRACTICE—Kuchibhotla M. Krishna, M.D., 4309 West 95th Street, Apt. #23, Oaklawn, IL 60453. Andhra (India) 1970. Clinic practice or hospital-based practice without calls or weekends. Available January 1981.

GASTROENTEROLOGY—Michael F. Fina, M.D., 134 North Street, Apt. 7, Newtonville, MA 02160. New York Medical College 1975. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available.

Abbasi Akhtar, M.D., 333 East Ontario Street, Apt. 1512-B Chicago, IL 60611. Liaquat (Pakistan) 1966. Also, general internal medicine and pediatric gastroenterology. Board eligible. Any type practice. Available September 1980.

GENERAL PRACTICE—Gregory A. Pistone, M.D., 2018 High Street, Haddon Heights 08035. Pennsylvania State 1979. Board eligible. Student health/adolescent medicine, pharmaceutical, ER, house physician. Available.

James Walter Warren, M.D., 67 Welton Street, New Brunswick, NJ 08901. Meharry 1973. Also general internal medicine. Any type practice. Available.

HEMATOLOGY/ONCOLOGY—P.S. Bala, M.D., 882-6 Clifton Court Circle, NE, Atlanta, GA 30329. Calicut (India) 1965. Board eligible. Any type practice. Available.

INTERNAL MEDICINE—Jay I. Lipoff, M.D., 3188 Skinner Mill Road, Apt. 9-G, Augusta, GA 30909. NYU 1975. Also, cardiovascular diseases. Board certified. Group or partnership. Available.

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Omprakash B. Ramani, M.D., 61-15 98th Street, Apt. 17-F, Rego Park, New York 11374. B. J. Medical (India) 1973. Board certified. Group or partnership. Available.

Stuart R. Schlanger, M.D., 105 North 31st Avenue, Omaha, NE 68131. Washington University 1977. Special interest, emergency medicine. Board eligible. Group or partnership. Available.

Richard Plotzker, M.D., 79 Holbrook Road, North Quincy, MA 02171. St. Louis University Board eligible. Group, clinic, institutional, or industrial. Available.

Khadar Baig, M.D., 2681 Arlington Drive, Apt. 303, Alexandria, VA 22306. Andhra (India) 1971. Subspecialty, gastroenterology. Board certified. Any type practice. Available.

Douglas R. Shumaker, M.D., 7861 Jefferson Street, Hummelstown, PA 17036. George Washington University 1977. Partnership, single or multi-specialty group, solo, emergency room. Available.

Joel M. Cohen, M.D., 1131 University Boulevard West. Apt. 1404, Silver Spring, MD 20902. SUNY-Downstate 1975. Subspecialty, cardiovascular diseases. Board certified. Single or multi-specialty group, partnership. Available.

Sybil Kramer, M.D., 68 Winchester Street, Brookline, MA 02146. SUNY-Downstate 1975. Subspecialty, endocrinology. Board certified. Single or multi-specialty group, partnership. Available.

Mark L. Friedman, M.D., 2901 S. King, Apt. 1003, Chicago, IL 60616. University of Chicago 1977. Subspecialty, emergency medicine. Single or multi-specialty group, partnership. Available.

Richard L. Rudolph, M.D., 124 Pearl Street, Red Bank 07701. CMDNJ 1976. Board eligible. Single or multi-specialty group, partnership. Available.

Robert H. Gordon, M.D., 5500 Wissahickon Ave., Apt. 405-C, Philadelphia, PA 19144. Jefferson 1975. Subspecialty, rheumatology. Board certified. Any type practice. Available.

Laurence J. Clark, M.D., 5038 Cliffhaven Drive, Annandale, VA 22003. Georgetown 1975. Subspecialty, emergency medicine. Partnership, solo, emergency room. Available.

Devi P. Misra, M.D., 7K University Terrace, Columbia, MO 65201. SCB Medical College (India) 1967. Subspecialty, pulmonary medicine. Board certified. Solo, institutional, group. Available.

Jon Allen Kotler, M.D., c/o Dept. of Medicine, 1356 Lusitana Street, Honolulu, HI 96813. Emory 1976. Subspecialty, emergency medicine. Board eligible. Single or multi-specialty group, partnership. Available.

Howard L. Kramer, M.D., 4 Longfellow Place, Apt. 803, Boston, MA 02114. Florida 1975. Board certified. Single or multi-specialty group, partnership. Available.

Mirza M. Ashraf, M.D., West St. Road, Carthage, NY 13619. King Edward (Pakistan) 1967. Subspecialty, cardiovascular diseases. Solo, single-specialty group, institutional. Available.

Mohamed M. Haq, M.D., 10555 Fondren, Apt. 422, Houston, TX 77096. Osmania

(India) 1973. Subspecialty, neoplastic diseases. Board certified. Single or multi-specialty group, research. Available.

Betty J. Barcevac, M.D., 2795 Shore Parkway, Apt. 1-G, Brooklyn, NY 11223. Guadalajara (Mexico) 1976. Group, partnership, single or multi-specialty group. Available.

Robert Lebow, M.D., 77 Grove Street, Montclair 07042. SUNY-Downstate 1977. Board eligible. Academic, partnership, multi-specialty group, industrial. Available.

Ira E. Kaplan, M.D., 523 East 14th Street, New York, NY 10009. SUNY-Downstate 1976. Special interest, cardiology. Board certified. Group, partnership. Available.

Hyung G. Kim, M.D., 1834 Beacon Street, Washington CH, OH 43160. Yonsei (Korea) 1970. Subspecialty, cardiology. Board certified. Group, partnership, or hospital-based practice. Available.

Akbar H. Obaray, M.D., 61-20 Grand Central Parkway, Apt. A-1407. Forest Hills, NY 11375. Grant (India) 1972. Subspecialty, pulmonary medicine. Board certified. Solo, group, or partnership. Available.

Bharat B. Parikh, M.D., 41-06 75th Street, Apt. 2, Elmhurst, NY 11373. Baroda (India) 1973. Subspecialty, pulmonary medicine. Board eligible. Solo or guaranteed group practice possibly leading to partnership. Available.

Fred Lewis, M.D., 7 Peter Cooper Road, Apt. 8-F, New York, NY 10010. Albany 1971. Subspecialty, endocrinology. Board certified (both). Group or hospital-based practice. Available.

Edward Lebowitz, M.D., P.O. Box 349, Lake Placid, NY 12946. SUNY-Downstate 1963. Board eligible. Group or partnership. Available.

Robert Fulop, M.D., 2678 Ocean Avenue, Apt. 5-E, Brooklyn, NY 11229. SUNY-Upstate 1978. Board eligible. Solo, partnership, group, or association. Available July 1981.

Joclekar S. Shankar, M.D., 9302 Cherry Hill Road, College Park, MD 20740. Grant (India) 1973. Board certified. Group, partnership, or hospital based. Available.

Byron S. Thomas, M.D., 513 Beachwood Court, Jacksonville, NC 28540. Pittsburgh 1975. Board certified. Group or partnership. Available November 1980.

Irwin Jaffe, M.D., 189-B Newport Road, Cranbury, NJ 08512. Zurich 1934. Board certified. Full or part-time industrial medicine or part-time with group. Available.

NUCLEAR MEDICINE—Philip A. Bardfeld, M.D., 160 West End Avenue, Apt. 8-E, New York, NY 10023. SUNY-Downstate 1961. Board certified. Single or multi-specialty group, institution. Available.

OBSTETRICS/GYNECOLOGY—Lemuel G. Villaneuva, M.D., 173 Lionhead Court, Baltimore, MD 21237. University of East (Philippines) 1974. Board eligible. Solo, group, HMO associate, hospital-based. Available.

Mina M. Chudgar, M.D., 15427 Jester Avenue, Baton Rouge, LA 70816. B.J.

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Medical College (India) 1972. Board eligible. Group, partnership. Available.

Mohammad Imtiaz Ahmad, M.D., 677 Central Avenue, Barboursville, WV 25504. Pakistan 1970. Board eligible. Solo with coverage when needed, small town. Available.

ONCOLOGY—Kumud S. Tripathy, M.D., 14 Slate Creek Drive, #5, Cheektowaga, NY 14227. P.W. Medical (India) 1972. Also, general internal medicine. Board certified (IM). Solo, group, institution-based, or partnership. Available.

Pradeep S. Mahal, M.D., 12415 Newbrook Drive, Houston, TX 77072. All-India 1974. Also, general internal medicine. Board certified (IM). Solo, single or multi-specialty group, partnership. Available.

OPHTHALMOLOGY—Ronald A. Serniuk, M.D., 502 Thompson Avenue, Roselle, NJ 07203. Georgetown 1971. Board eligible. Partnership or solo. Available.

Mitchell Schuman, M.D., 1675 York Avenue, New York, NY 10018. New York Medical 1975. Board eligible. Any type practice. Available.

Edward A. Pulice, M.D., 49-20 Hanford Street, Apt. #1, Douglastown, NY 11362. NYU 1976. Group, partnership, solo. Available.

PATHOLOGY—Uma Raghavan, M.D., Dept. of Pathology, Norwalk Hospital, Norwalk, CT 06850. Delhi (India) 1973. Both AP/CP. Board certified. Group. Available.

Joseph V. Napolitano, M.D., 7 Howland Road, Middletown, NJ 07748. Bologna (Italy) 1972. Special interest, anatomic and clinical pathology. Board certified (both). Institutional, group, or partnership. Available.

Doroteo A. Vicente, M.D., 36976 Farmbrook Drive, Mt. Clemens, MI 48043. Santo Tomas (Philippines) 1972. Both AP/CP. Board eligible. Group or partnership. Available.

PEDIATRICS—Norma P. Samuy, M.D., 1180 East and West Road, West Seneca, NY 14224. Santo Tomas (Philippines) 1970. Board eligible. Solo, partnership, clinic. Available.

Soni Mahesh, M.D., 100 Hospital Plaza, #811, Paterson 07503. Baroda (India) 1973. Board eligible. Partnership or solo. Available.

Nathaniel D. Wycliffe, M.D., 1563 Boston Avenue, Bridgeport, CT 06610. Dacca (Pakistan) 1972. Board certified. Group, solo, associate. Available.

Sunila Mehrotra, M.D., 829 Main Street, Apt. C, Belleville, NJ 07109. Delhi (India) 1974. Board eligible. Group/partnership. Available July 1981.

David R. Croughan, M.D., 12 Harbor Boulevard, East Hampton, NY 11937. Guadalajara (Mexico) 1973. Board eligible. Group, partnership. Available.

PSYCHIATRY—Charles Goldfarb, M.D., 121 Deerhaven Road, Mahway 07430. Buffalo 1956. Board certified. Partnership in single or multi-specialty group. Available.

Paul L. Maitheny, M.D., 99 Pawnee Road, Lakewood, NJ 08701. Graz (Austria) 1951. Board eligible. Any type practice. Available.

Ahmed Naimetulla Syed, M.D., 3430 Kay Street, Apt. D-11 Colony East, Columbia, SC 29210. Kakatiya (India) 1971. State hospital, university, institution, or correction center. Available.

PULMONARY DISEASES—Susan Kallos Sekely, M.D., 7528 Arlington Expressway (220), Jacksonville, FL 32211. Budapest U. of Med. Sciences 1952. Board certified. Hospital, group, or state institution. Available.

Krishna Rao, M.D., 1575 Boston Avenue, Apt. C-9, Bridgeport, CT 06610. Osmania (India) 1973. Also general internal medicine. Board certified. Solo, group, hospital, partnership. Available.

RADIOLOGY—Donald S. Cohen, M.D., 1089 Briar Way, Fort Lee 07024. Guadalajara (Mexico) 1975. Board eligible. Group, partnership, solo (will consider purchase). Available.

Bernard S. Jay, M.D., Box 1356, Madison, CT 06443. Georgetown 1971. Special interest, diagnostic radiology. Also, general internal medicine. Board certified. Group or hospital-based (shore areas), all aspects of ultrasound. Available.

SURGERY, GENERAL—B. Paulauskas, M.D., 5700 Arlington Avenue, Apt. 2-K, Riverdale, NY 10471. Lithuania 1972. Board eligible. Group, partnership, solo. Available.

Mohan Lal Sarwal, M.D., 42-52 Union Street, Apt. 117, Flushing, NY 11355. Govt. Medical, Patiala-Punjab (India) 1968. Group, partnership, solo. Available.

Mohammad A. Arain, M.D., 3420 Deanza Avenue, Merced, CA 95340. Liquat Medical (Pakistan) 1969. Board eligible. Partnership, single or multi-specialty group. Available.

Ranvir S. Achreja, M.D., 2400 Southloop West, #1502, Houston, TX 77054. MGM Medical (India) 1969. Board eligible. Solo, single or multi-specialty group. Available.

Gary G. Wind, M.D., 6202 Singleton Place, Washington, DC 20034. Temple 1970. Special interest, colon and rectal surgery. Board certified. Single or multi-specialty group, research. Available.

Joseph Dotan, M.D., 1206 East 49th Street, Brooklyn, NY 11234. Hebrew University (Israel) 1966. Special interest, oncology. Board eligible. Multi-specialty group, research, partnership. Available.

Ronald H. Sultan, M.D., 7750 Roosevelt Boulevard, Eden Roe Apt. 216, Philadelphia, PA 19152. NYU 1973. Special interest, abdominal surgery. Board eligible. Partnership, solo, single-specialty group. Available.

Nirmal E. Pathak, M.D., 324 Seminole Drive, Montgomery, AL 36117. N.R.S. Medical (India) 1963. Board certified. Any type practice. Available August 1980.

Michael S. Weingarten, M.D., Henry Ford Apartments, 1350 W. Behune Ave., Apt. 1207, Detroit, MI 48202. Columbia 1974. Board eligible. Single or multi-specialty group, partnership. Available.

Nardo T. San Diego, M.D., 171 Davis Avenue, Piscataway, NJ 08854. Far Eastern (Philippines) 1961. Board eligible. Solo or partnership. Available.

Seeplaputhur G. Sankar, M.D., 128 Normandy Drive, Norwood, MA 02062. Prince of Wales (India) 1974. Special interest, vascular surgery. Board eligible. Group, partnership, solo. Available.

Jung T. Tsai, M.D., 240 Willoughby Street, Apt. 8-D, Brooklyn, NY 11201. China Medical 1971. Board eligible. Solo, partnership, group. Available.

Absalon Gutierrez, M.D., 1925 Pacific Avenue, Atlantic City, NJ 08401. Nicaragua 1972. Board eligible. Group or emergency room. Available.

Jeffrey E. Lavigne, M.D., 1591 North Van Buren Avenue, Ottumwa, Iowa 52501. SUNY-Downstate 1970. Also, peripheral vascular surgery. Board certified. Any type practice. Available.

Juanilito N. Seldera, M.D., 4114 Ninth Avenue, Brooklyn, New York 11232. Univ. of East (Philippines) 1972. Special interest, surgical oncology. Board eligible. Group, partnership, solo. Available.

Ronald Bagner, M.D., 3450 Wayne Avenue, Apt. 24-A, Bronx, NY 10467. St. Louis 1974. Board eligible. Any type practice. Available.

SURGERY, ORTHOPEDIC—Joseph D. Jannuzzi, M.D., P.O. Box 6012, Lake Charles, LA 70606. Wayne State 1962. Board certified. Partnership, single or multi-specialty group. Available.

SURGERY, PLASTIC—Edmond B. Cabbabe, M.D., 5064 Clairidge Drive, Apt. 214, St. Louis, MO 63129. Damascus (Syria) 1972. Board eligible (general and plastic surgery). Solo or partnership. Available August 1980.

SURGERY, THORACIC—Louis T. Kanda, M.D., 12000 Edgewater Drive, Lakewood, OH 44107. George Washington 1970. Board certified (general surgery). Group, partnership, institutional. Available August 1980.

Khalid Y. Khan, M.D., 8 Gulf Lane, Galveston, TX 77550. King Edward (Pakistan) 1970. Also, general surgery. Board eligible (general surgery). Solo, institutional, single-specialty group. Available.

Anne-Marie Régal, M.D., 708 Beach Avenue, Bronx, NY 10473. Boston 1970. Board eligible. Single-specialty group, partnership, or institutional. Available.

SURGERY, UROLOGICAL—Steven H. Paletsky, M.D., 841 Ridgeview Drive, Medina, OH 44256. Med. U. of SC 1973. Board eligible. Partnership, solo, single-specialty group. Available.

Marc B. Osias, M.D., 12205 Morocco, NE, Albuquerque, NM 87111. Yale 1972. Board eligible. Partnership, single or multi-specialty group. Available.

William A. Mandour, M.D., 149 Elm Drive, Rochester, NY 14609. Loyola-Stritch 1974. Partnership, single or multi-specialty group. Available August 1980.

Harry F. Reiss, M.D., 2100 East Chester Road, Apt. 2-K, Bronx, NY 10461. Guadalajara 1973. Board eligible. Single or

multi-specialty group, partnership. Available.

Sidney Goldfarb, M.D., 305 E. 24th Street, New York, NY 10010. Einstein 1975. Single or multi-specialty group, partnership, solo. Available.

UROLOGY—G. Rosenberg, M.D., 205 West 15th Street, New York, NY 10011. NYU 1974. Board eligible. Partnership, group, solo, multi-specialty group. Available.

Balakrishna Sundar, M.D., 912 Parkview Lane, Des Plaines, Illinois 60016. Maulana Azad (India). Board eligible. Group, partnership, solo. Available.

Eliahu Koren, M.D., 5700 Arlington Avenue, Apt. 6-J, Riverdale, NY 10471. Jerusalem 1968. Board eligible. Group, partnership, solo. Available.

Krishan G. Gupta, M.D., 21 Losson Garden Drive, Buffalo, NY 14227. Kanpur (India) 1964. Board eligible. Solo, partnership, group. Available.

Kirit S. Shah, M.D., 32 Grand Canyon Drive, Madison, WI 53705. Baroda (India) 1971. Board eligible. Group, partnership or solo. Available July 1981.

NJSIM Applauded

The American Society of Internal Medicine recently named the New Jersey Society of Internal Medicine component as the recipient of the 1980 "Special Recognition" award. The award is conferred upon the ASIM component which has performed outstanding service to the Society. ASIM recognized the New Jersey SIM for demonstrating organizational effectiveness in identifying and resolving member problems. Through these efforts and leadership, much has been achieved for the internists in the state.

NJSIM President Frank L. Malta, MD., a board certified internist from Toms River, accepted the award on behalf of the Society at the ASIM Annual Meeting held May 15 to 18, 1980 in Washington, D.C.

LETTERS TO THE JOURNAL

Legal Counsel and State Board of Medical Examiners

April 24, 1980

Gentlemen:

Your proposal concerning legal counsel for physicians who appear before the New Jersey Board of Medical Examiners is quite interesting and I think it is appropriate. Unfortunately, I must object to the attorney who has instigated many of the problems which you list in your proposal dated March, 1980.

This man has used his position in the Attorney General's Office to cause many of these procedures to be utilized and I believe that he is not the appropriate person for the proposed service based upon his record with the Board of Medical Examiners when he was in the Attorney General's Office.

If the State Medical Society wishes to have documentation of his unsuitability, I shall be happy to request that my attorney provide same to you. It is possible that an attorney can reverse his field completely and work effectively on one side of the court shortly after he was on the other side, but I don't think this is really possible.

(signed) Bertram M. Kummel, M.D.

May 5, 1980

Dear Doctor Krosnick:

The letter of Doctor Kummel illustrates a frequent misconception of many people concerning the role of the advocate in the adversary system of justice that exists in the United States.

Attorneys representing governmental agencies have the obligation to zealously pursue prosecutions when they believe the charges are supported by probable cause. Likewise, the defense attorney must challenge the State and its agencies to the test of proofs even if his client is guilty, if that client has chosen to plead "not guilty."

Obviously, the attorney in question did utilize, and quite aggressively, the tools available to the prosecution. Had he acted otherwise while representing the State, it would have been an indication of misconduct and unethical behavior on his part.

Likewise, I fully expect him to use all of his ability and the procedures available to him in the defense of those enrolled in the Medical Society of New Jersey legal plan.

Incidentally, most defense attorneys spend their early years either representing plaintiffs or prosecuting cases on behalf of the government. It is only in this fashion that they really can secure the experience and skill necessary to represent the defendant.

(signed) Vincent A. Maressa
Executive Director

JMSNJ and Index Medicus

May 5, 1980

Dear Sirs:

The Journal of the Medical Society of New Jersey is being received and indexed regularly, as it has been for many years.

Because I don't know the specific articles that your readers were looking for, I am unable to explain why they could not find them. There are several possible reasons. Because of the time required for processing, the articles that you have published in 1980 are not yet in MEDLARS. It is possible that an occasional article is difficult to find because of personal or computer error. I am sure that you will understand this possibility in a system that handles a quarter of a million articles per year.

If you will kindly let us know the title and author of any "missing" article, and the volume and issue of its publication, we will either confirm its presence in MEDLARS, or correct the omission.

(signed) Clifford A. Bachrach, M.D.
Editor, *Index Medicus*

CME CALENDAR

ANESTHESIOLOGY

Sept.

9 **Anesthesia for Patient with Ischemic Heart Disease and Recent MI**
7:30 p.m.—Helene Fuld Medical Center, Trenton
(Helene Fuld Medical Center)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Aug.

12 **Hypertension**
8-9:30 p.m.—Shore Memorial Hospital, Somers Point
(Shore Memorial Hospital and AMNJ)

Sept.

9 **Antibiotics**
11 a.m.—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

9 **Respiratory Arrest**
8-9:30 p.m.—Shore Memorial Hospital, Somers Point
(Shore Memorial Hospital and AMNJ)

15 **Special Bacterial and Serological Testing**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

16 **Rationale/Indications for Mini-Heparin**
12 noon—St. Mary's Hospital, Orange
(St. Mary's Hospital and AMNJ)

17 **Proper Use of Prophylactic Antibiotics**
11:30 a.m.—Rahway Hospital
(Rahway Hospital and AMNJ)

19 **Gastroenterology—Colitis**
12 noon—Freehold Area Hospital
(Freehold Area Hospital and AMNJ)

23 **Coronary Artery Disease**
11 a.m.—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

23 **New Jersey Blood Club**
7:30-9 p.m.—Coachman Inn, 10 Jackson Dr., Cranford
(New Jersey Blood Club and AMNJ)

24 **Recent Advances in Internal Medicine and Therapeutics**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(Middlesex General Hospital and AMNJ)

25 **Immunology '81**
4-6 p.m.—Institute for Medical Research Copewood St., Camden
(Institute for Medical Research and AMNJ)

30 **Proper Use of Antibiotics**
2 p.m.—Ancora Psychiatric Hospital
(Ancora Psychiatric Hospital and AMNJ)

NEUROLOGY/PSYCHIATRY

Aug.

5 **Diagnostic and Statistical Manual of Mental Disorders DSM-III**
10 a.m.-12 noon—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

7 **Psychotropic Medication for Depressed Elderly**

14 **Acute Psychoses**

21 **Psychiatric Disorders in Drug Abusers**

28 **Tricyclic/MAOI Combinations**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

Sept.

4 **Lithium—Other Uses and Cautions**

9 **Psychodynamics in Prescribing**

18 **Patient Education—Medication and Self-Medication**

25 **Adverse Cardiac Reactions to Psychotropics**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

17 **Geriatric Psychopharmacology: Treatment of Depressed, Elderly Patients**
1:30 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

RADIOLOGY

Sept.

4 **Ultrasonography of the Breast**
7:30-9:30 p.m.—St. Barnabas Medical Center, Livingston
(St. Barnabas Medical Center and AMNJ)

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastic, and Vascular Surgery.)

Sept.

18 **Spinal Cord Injury Service Quarterly Meetings**
1-2:30 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

23 **Regional Flaps: Use in Reconstructive Head and Neck Surgery**
8-10 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

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Wednesdays, 4 to 7 P.M. October 10 to December 17, 1980

Course Directors: Saul J. Farber, M.D., Frederick H. King Professor of Internal Medicine and Chairman,Department of Medicine; Louis Shenkman, M.D., Associate Professor of Medicine

COURSE DESCRIPTION

317. This highly successful clinical problem-solving course is for experienced physicians practicing general internal medicine. The objective is to analyze, systematically, a series of difficult patient management problems commonly encountered in office and hospital practice. Special attention is given to diagnostic and therapeutic dilemmas presenting in the ambulatory setting.

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30 Category I credit hours; 30 AAFP prescribed credit hours (pending)

Also . . .

CLINICAL TUTORIAL — 152. Dermatology For The Practicing Physician

Wednesdays, 1:30 to 3:30 P.M. September 24 to October 22, 1980

David L. Ramsay, M.D., Associate Professor of Dermatology

Specifically designed for non-dermatologist physicians, especially those involved in primary care practice. Major emphasis is on unraveling diagnostic possibilities in a presenting dermatological complaint and providing practical guidelines for relieving the patient's symptoms and promoting resolution while the evaluation is proceeding. Special attention is given to the most commonly encountered dermatological problems in general office practice. Teaching includes lectures, case presentations, group discussion and a forum for presenting specific diagnostic and management problems from the registrant's practice.

10 Category 1 credit hours; 10 AAFP prescribed credit hours (pending)

CLINICAL TUTORIAL — 300. Introduction to Non-Invasive Cardiovascular Diagnosis

Wednesdays, 1:30 to 3:30 P.M. October 29 to December 3, 1980 (No session November 26)

Dr. Itzhak Kronzon, M.D., Associate Professor of Clinical Medicine

This course is for the non-cardiologist physician. It provides clear and specific guidelines for the application of non-invasive diagnostic procedures in ambulatory and hospital practice to assist the physician in properly ordering and sequencing these examinations, in interpreting reports from consultants and in better understanding the clinical literature. Each presentation begins with a clear description of the physical principles underlying the procedure. This is followed by a review of indications, contraindications and test limitations. There is a comparison of information from non-invasive with invasive (catheterization) procedures with special reference to the value of the information in patient management as well as risks, costs and patient suffering. Case studies illustrate how non-invasive procedures are applied, their proper sequence in the diagnostic work-up and in their interpretation. The instrumentation for each procedure is described and demonstrated and there are review practice sessions for interpreting diagnostic data. Topics include: Basic Concepts of M-Mode Echocardiography including Recognition of Valvular, Congenital and Pericardial Disease and Cardiomyophathies; Radionuclides including the Evaluation of Cardiac Performance and the Recognition of Ischemic Disorders; Holter Monitoring; Systolic Time Intervals; Phonocardiography, Apexcardiography and Arterial and Venous Tracings; When to invade: The Limitations of Non-Invasive Cardiology; Stress Testing; Dynamic Imaging. This course does not require any previous familiarity with non-invasive cardiology.

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NJ 7/80

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OBITUARIES

Dr. Michael J. Aria

On May 22, Michael J. Aria, M.D., a member of our Bergen County component from Ramsey, died tragically when he was crushed by a 1200 pound concrete slab which fell from a retaining wall by his home. A native of Jersey City, born in 1927, Dr. Aria was graduated from Georgetown Medical School, class of 1953, and pursued graduate training in pediatrics, becoming board certified in that specialty. He was a Fellow of the American Academy of Pediatrics and was an active member of the staffs of the Valley Hospital in Ridgewood and the Good Samaritan Hospital in Suffern, New York. His father, Michael H. Aria, now retired, practiced surgery in Jersey City.

Dr. Richard R. Gove, Jr.

A former Ocean County deputy medical examiner, Richard R. Gove, Jr., M.D., died on May 23 in Shore Memorial Hospital, Somers Point. A native of Camden, born in 1918, Dr. Gove had earned his medical degree from Temple University Medical School in 1943 and practiced family medicine in Elkins Park, Pennsylvania before moving to Brant Beach in 1946. He was a Fellow of the American Academy of Family Physicians and was on the staff at the Community Hospital in Toms River and the Southern Ocean County Hospital in Manahawkin. Dr. Gove had been president of his county medical society (Ocean) and secretary of the New Jersey Chapter of the Academy of Family Physicians. He was active in community affairs and was school physician for all of the schools on Long Beach Island and for the Southern Regional Middle and High Schools in Manahawkin. During World War II, Dr. Gove served with the medical department of the United States Navy. A son, Ronald C. Gove is a practicing physician in Pleasantville.

Dr. Joseph Judd, Jr.

Joseph Judd, Jr., M.D., a member of our Union County component, died on May 19 at Elizabeth General Hospital. A native of Elizabeth, born in 1913, Dr. Judd had earned his medical degree from Albany Medical College in 1943, and after general internship and a residency in psychiatry at the Veterans Administration Hospital in Lyons, he established a practice in Elizabeth. Dr. Judd was board certified in his specialty and was a Fellow of the American Psychiatric Association. He was affiliated with Elizabeth General Hospital, ultimately becoming chairman of the department of psychiatry.

Dr. T.P. McFarland, Jr.

One of Atlantic County's well-known physicians, Thomas P. McFarland, Jr., M.D., died in Wesley Manor Nursing Home in Ocean City after a long illness. A native of Philadelphia, Dr. McFarland was graduated from Hahnemann Medical College in 1950 and practiced internal medicine and cardiology in Mays Landing for 22 years. He was affiliated with Shore Memorial Hospital in Somers Point. Dr. McFarland was active in civic affairs and had been president of the Atlantic County Heart Association and chairman of the Annual Heart Fund Drive. He was physician for township schools in the area, the Oakcrest High School, the Atlantic County Health Department, and the Hammonton Cancer Clinic. During World War II, Dr. McFarland served with the medical department of the AUS. He was 59 years old at the time of his death.

Dr. Harry G. Rinzler

One of Passaic County's senior members, Harry G. Rinzler, M.D., of Passaic, died on May 3 in Passaic General Hospital where he had been affiliated all of his professional life. A native of Passaic, Dr. Rinzler was graduated from St. Louis University in 1927 and pursued a career in general practice in his home community. He had been active in civic affairs and was police and fire surgeon for the city of Passaic, as well as chief medical examiner and school physician. In 1977 Dr. Rinzler was a recipient of MSNJ's Golden Merit award indicating fifty years of medical practice. He was 79 years old at the time of his death.

Dr. John A. Stabile

One of Mercer County's well-known practitioners, John A. Stabile, M.D., of West Trenton, died on May 19 in Helene Fuld Medical Center, Trenton, where he was a member of the staff. A native of New Jersey, born in 1907, Dr. Stabile graduated from Hahnemann Medical College, class of 1935, and had practiced general medicine in the Trenton area since 1936.

Dr. Frank A. Wilcox

On March 26, Frank A. Wilcox, M.D., a member of our Hudson County component from West New York, died suddenly in Palisades General Hospital, Weehawken. Born at the turn of the century, Dr. Wilcox was graduated from the University of Toronto Medical School in 1924, and returned to Hudson County to practice general medicine there until his retirement two years ago. During World War II Dr. Wilcox served with the department of medicine of the AUS for three years. He received the Medical Society's Golden Merit Award in 1974 honoring his 50 years as a physician.

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POSTGRADUATE COURSE FOR PHYSICIANS

Recent Advances in Internal Medicine and Therapeutics

Twenty-Fifth Series

Sponsored by: **The Academy of Medicine of New Jersey and New Jersey State and Middlesex County Chapters of the American Academy of Family Physicians and Middlesex General Hospital and Rutgers Medical School**

Meeting Place: Auditorium, Roosevelt Hospital, Menlo Park, New Jersey

Date: Wednesdays, 9 to 11 a.m. starting September 24, 1980 and ending May 27, 1981

Beginning this September and ending May 27, 1981, the Postgraduate Course "Recent Advances in Internal Medicine and Therapeutics" will be given by Middlesex General Hospital of New Brunswick as in previous years. However during 1980-1981 the lectures will be held in the auditorium of the new West Wing of Roosevelt Hospital, Menlo Park, New Jersey. The 34 sessions of the Course are approved for 68 prescribed AAFP credits and for 68 hours of the Continuing Education Requirement of the Medical Society of New Jersey and the Physicians Recognition Award of the AMA.

As in previous years the 25th year of the Course is designed to present clear and concise reviews of important advances in internal medicine that are of interest to family physicians and internists in office practice. All 34 of the two-hour Wednesday morning sessions are conducted by outstanding physicians of the medical faculties of New York, Boston, Philadelphia, and other metropolitan centers and members of the faculty of Rutgers Medical School. During the sessions opportunity is given to discuss with the speakers aspects of clinical problems that arise in the care of individual patients. The 1980-1981 series will be devoted to discussions of: Heart and Blood Vessels, Lungs, Nervous System, Genitourinary Tract, Endocrinology and Metabolism, Gastrointestinal Tract, OBS/GYN, Dermatology, Genetics, Shoulder Pain, and other subjects.

The opening session is set for Wednesday, September 24, 1980.

IF YOU ARE INTERESTED IN ENROLLING AND HAVE NOT RECEIVED AN APPLICATION FORM IT IS IMPORTANT THAT YOU WRITE OR PHONE IMMEDIATELY TO THE CHAIRMAN OF THE COURSE, DR. S.E. MOOLTEN, ROOSEVELT HOSPITAL, MENLO PARK, NEW JERSEY (201) 321-6835.

The fee for the entire Course (34 sessions) is $275. For interns and residents $75.

August 1980

Journal of the Medical Society of New Jersey

Risk of Cigarette Smoking
N. Hymowitz, Ph.D.

Pancoast Tumor
M. Yacoub, M.D.
C. Hupert, M.D.

Confessions of a Female Chauvinist
E. T. Shapiro, M.D.

Synovianalysis
S. D. Solomon, M.D.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Cover

The cover is a pen-and-ink drawing by Elizabeth Ruggles. Miss Ruggles is a well-known teacher and painter in the area and formerly was staff artist for the New Jersey State Department of Health.

Rehabilitation is a Team Effort

New Jersey Rehabilitation Hospital, located by Exit 145 of the Garden State Parkway, is a specialty hospital which treats catastrophic injuries to spinal cord and brain, stroke, quadriplegic, paraplegia, loss of limb, musculo-sketetal injuries, neck and low back injuries, and other mental and physical impairments, often resulting from automobile or work accidents.

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Accident Facts. Chicago, Illinois, National Safety Council, 1974.

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NJ APPELLATE DECISION UNSEATS SOME PHYSICIANS FROM RULE 4:21 PANELS

A recent Appellate Review decision concerning *Rule 4:21* states that, effective May 16, 1980, physicians who have a pending malpractice suit will not be able to sit as panelists. The majority opinion of the Court decided it was essential that each of the members of the panel be thoroughly impartial and free from influence of any factor that would affect or "would even create the risk of affecting impartiality." If a physician is a defendant in a pending malpractice action, there remains the risk that such a circumstance might have some influence "upon his ability to remain detached and disinterested . . . albeit unconsciously and unintentionally."

The minority opinion argued that the draftsman of *Rule 4:21* "considered that the benefits to be derived from the physicians' participation on *Rule 4:21* panels offset the risk of biased findings and conclusions arising from that participation, particularly in light of the safeguards provided by the two other panelists." The minority opinion further stated, "It must also be borne in mind that the judge will be conferring with the doctor in the disposition of the *Rule 4:21* proceeding and is therefore in the best position to detect a tendency to decide a fact or reach a conclusion on any basis other than its merits. The dissenting judge stated that he had no doubts that the judges' awareness of bias on the part of either of the two panelists, however belated, would result in aborting the hearing and commencing anew with a more impartial panelist."

The Appellate Court's decision is being appealed to the New Jersey State Supreme Court. (NJ App. 1980 *R*.4:21 A-1852-79)

GUIDELINES FOR INFORMED CONSENT

According to Henry B. Alsobrook, Jr., J.D., physicians realize that a signed consent form is not a guarantee against a medical malpractice suit. But, *where* a consent form is signed can make a difference between the winning and losing of law suit.

In his article "Why You Can't Rely on a Hospital Consent Form" in the May issue of *Medical Economics,* Mr. Alsobrook, suggests that physicians have consent forms signed in their office. An office setting presents an atmosphere more conducive to patient reflections and discussions of a procedure than the stressful atmosphere of a hospital.

Mr. Alsobrook, who is general counsel for the Louisiana State Medical Society, recommended that the patient sign three forms—"one to remain in the patient's permanent record, one to be taken to the hospital, and one to be kept in the patient's office file in case the form for the hospital is lost. Then if the hospital also wants its own form signed there, so be it. I find most hospital consent forms so general that they're inadequate anyway."

Mr. Alsobrook also advises physicians to provide written material on the procedure and to stress the complications and risks of the procedure. If the patient is aware of the most dire consequences, paraplegia or death, a lesser complication, such as an infection, would be easier to defend in an informed consent case.

Mr. Alsobrook further advised that the patient's family be involved with the procedural discussions as well as serve as witness to the signing of the consent forms. Office staff also may be used as witnesses in the event a family member is unavailable.

It is most important that the physician makes a note on the patient's chart that the procedure was fully discussed and a consent form had been signed. It is further advised that the physician sign or initial the notation.

"If complications do occur, remind the patient as soon as possible in a *gentle and tactful manner* that what happened was one of the hazards discussed in your office. A physician who follows these few simple guidelines will be less likely to hear a patient-turned-plaintiff tell a malpractice jury, "I was never properly informed."

SIBLING RIVALRY?

One of the causes of action involved in a recent suit arising out of an alleged unsuccessful tubal ligation was a request for damages by the unwanted child's siblings. The New York Appellate Court ruled that the brothers of a newborn child could not recover on the theory that they were deprived of the care, affection, training, and financial support they would have received had there not been the extra child to support. (Sala v Tomlinson, 422 NYS 2nd 506) (NY Sup. Ct., App. Div., Dec. 6, 1979)

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*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

PHYSICIAN INSURANCE COMPANIES CONTINUE TO GROW

The following is a data report of physician-owned/medical-society-created liability insurance companies as of May 1980.

State	Policy Holders Feb 79	Policy Holders May 80	Average Premium Feb 79	Average Premium May 80	Capital and Surplus (000)	Assets (000)
AL	2460	3200	$3100	$3500	$ 4,733	$30,700
AZ	2400	3460	3000	3987	16,000	48,300
MIEC CA	2000	2475	5000	5600	12,000	44,000
NORCAL MUTICAL CA	4000	4850	8200	7100*	21,300	94,800
SCPIE CA	3000	6000	6800	6500*	24,900	83,600
FL	5400	6400	5280	4827*	7,000	56,000
IL	7000	7840	5250	5511	32,100	160,700
KY		585		2100	1,800	2,100
ME		767		2045	1,800	3,300
MD	4000	4600	3100	3700	5,000	62,300
MI	2447	2900	5320	5500	9,300	49,300
MS	800	1093	1846	4023	2,000	4,700
MO	250	1150	3000	2500*	2,500	4,900
NJ	5200	5800	5000	5345	22,500	99,000
NM	900	1000	2400	2475	4,000	13,800
NY	17000	17900	6000	5918*	49,700	517,200
NC	4300	4600	1000	1015	1,250	9,200
OH	2800	3255	4500	4211*	9,900	57,800
OK		3000		2300	1,700	6,900
PA	4660	5200	4671	3565*	9,000	68,000
TN	4600	4416*	2250	2694	7,995	38,600
TX		1200		3100	3,500	7,600
UT		890		2550	2,400	5,400
TOTAL INSURED		92581				

* Denotes Decrease

PIAA THIRD ANNUAL MEETING**

The Physician Insurers Association of America is the national organization of doctor-owned professional liability insurance companies. The 24-member companies, representing 22 states, are committed to developing, facilitating and promoting sound underwriting practices in the medical professional liability insurance field.

Attending this third Annual Membership meeting, June 5 to 7 at the Crown Center Hotel in Kansas City, Missouri were 127 members and 55 non-members. Workshops, lectures and meetings, designed to exchange ideas and discuss common areas of interest, were scheduled throughout the three-day session. The workshops which began on Thursday afternoon were a very popular activity. Along with representatives of other member companies, Mr. Peter Sweetland, President of the New Jersey State Medical Underwriters, and Mr. Manuel Puebla, Executive Vice President of Donald J. Fager & Associates conducted the Administrative Services Workshop; Mr. Bernard Genest, Director, Claims Administration, NJSMU, led the Claims Workshop. All the participants felt these open-forum discussions were an excellent way to learn the state of the art of their province in the insurance field.

Friday was devoted to the general membership meeting and lectures on various aspects of physician-owned insurance companies—from legal liabilities to the controversial subject of tort reforms. J. Anthony Manger, General Counsel of PIAA, spoke about Directors' and Officers' liability, "bad faith" actions and civil actions. Mr. Gerald I. Lenrow, partner of Coopers & Lybrand, New York, explained tax planning, reinsurance and their impact on reported results. Mr. Thomas H. Swain, Executive Vice President, St. Paul Fire and Marine Insurance Company, discussed the future of the medical professional market and the view, by a major insurer, of the doctor-owned company's role. He stressed the need for all insurers, doctor-owned and commercial alike, to cooperate in reducing causes of loss.

Dr. Robert S. Brittain, President of Medical Liability Consultants Program, Inc., Denver, Colorado, and Mr. Ronald Trayner, Attorney with Musick, Peeler & Garrett, which is the Staff Counsel to the California Hospital Association Insurance Committee, spoke on tort reforms—"Are They Working?". Dr. Brittain, approaching from the medical point of view, believes that tort reforms are having little impact and much more effort should be put into loss prevention. Mr. Trayner explained the California Tort Reform package, pointing out the areas that he feels have been effective and those which have been less than successful.

All of the talks elicited response from the audience and there were several prolonged question and answer sessions. The need for good loss prevention plans was a continuous theme and it was generally agreed that the PIAA should be instrumental in developing and establishing such programs for its membership.

Evening gatherings gave the non-member consultants, actuaries, underwriters and suppliers the chance to meet informally with the members and introduce their companies and services. This was the first year that non-members were invited to participate in the annual meeting and it is expected that future meetings will attract an even larger non-member attendance.

The meeting closed at noon on Saturday after the completion of the workshops, continued from Thursday. The overall response to this, the largest of the PIAA functions to date, was positive and enthusiastic. Both members and non-members appreciated the opportunity to meet their contemporaries from around the United States and felt the meeting was educational and informative. The next annual meeting will be held in May, 1981 in San Francisco.

**Prepared by Deborah Menaker, Administrator of PIAA

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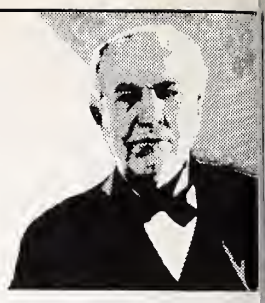

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EDITORIALS

A New Ballgame

A colleague recently complained that "the ballgame is over!" He was speaking rather bitterly of the imposition of special assignment nurses, health educators, "therapists" of all kinds (physical therapists, ventilation therapists) and a general assortment of government-sponsored buttinskies between the physician and his patient. Some of these interlopers are physician collaborators, in his view, who are not unlike their European counterparts in World War II, when they provide aid and comfort to the enemy. The idea was expounded in a bitter and cynical manner, but not without some merit.

In the first place, "others" are deciding who shall be eligible to enter the hospital on the basis of a listed diagnosis (which is sometimes preliminary and usually incomplete) or a problem list which may not fit readily into a shipshape diagnosis. The physician's "sense" of the health problem—after dealing with it for hours, days, weeks, or months—may instinctively suggest the need for separation from the family and/or environment or the potential value of a concentrated look at the difficult patient in the test-tube atmosphere of a hospital. Either the separation or the scrutiny or both may prove to be therapeutic, but this earns no Brownie points with third party payers.

Not only is the passport to admission dependent on the opinions of a perimetric "other," but the duration of the hospital voyage is conditioned by that all-important admission diagnosis, which, as we all know, rarely correlates perfectly with the discharge diagnosis. Unexpected problems have a way of popping up—for example, anemia due to cecal carcinoma in a fatigued, depressed, middle-aged homemaker or vertebral-basilar artery insufficiency in the retired elderly gentleman whose complaint is that abused generic term, "dizziness."

Once in the hospital, the pressures on the physician and his diagnostic and therapeutic plan begin to mount. The dietary department will not accept "diabetic diet" or "low-sodium diet," but demand carbohydrate, protein, fat, and calories by-the-number, distribution of the meal plan, and the specific quantity of sodium in grams. The x-ray department and the operating room secretaries will schedule procedures at their convenience—usually on a five-day-week basis.

The coronary care unit nurse will "zap" your patient with a rhythm-restoring jolt of electricity, or shove in a bolus of lidocaine without your permission, and sometimes without your knowledge, if shifts change and nurses are too busy reporting to other nurses to talk to you—the attending physician.

A worse situation is sometimes encountered by the non-specialist in pulmonary medicine who may be awakened at 2 a.m. by the ICU nurse who recites a string of arterial blood gas values, central venous pressure levels, and a trail of questions which end with something about a T-piece trial. It's intimidating on its face, but infuriating at 2 a.m., even though it's for the patient's good.

Almost the instant your patient's body starts to warm the hospital bed, a discharge planning nurse or social worker scrutinizes the chart, especially your admission note, and leaves a prominent stamped form on your order sheet which requires you to indicate your discharge plan for the patient. You don't even know what's wrong with the patient, and they want discharge plans!

The non-physiatrist physicians among us—which constitute the vast majority—tend to order our own physiotherapy modalities. The minute we do, some eager beaver in the physiotherapy department presses us to consider transcutaneous nerve stimulation therapy in addition to good, old hot packs for the treatment of sciatic neuropathy.

Even our friend, the hospital pharmacist, is bugging us about ordering combinations of antibiotics that are incompatible, or warning us to reduce the insulin dose when we prescribe the new single-component beef-pork insulin or the purified pork insulin preparations which presently are replacing the "old" insulins.

Laboratory technicians and x-ray technicians also can be a pain in the gluteus maximus. Order an ultrasound study of the pancreas in an obese patient and the technician probably will call you to suggest that a CT scan may provide more information. If the blood urea nitrogen or creatinine is elevated, she may refuse to do an intravenous pyelogram. Lately, we get calls from bacteriology technicians, now referred to as microbiologists, who tell us that we are prescribing the wrong antibiotic for the organism that is culturing from our patient's blood!

What does all this mean? Is the ballgame over for the doctor? Not in the least! All these are signs of progress or change or whatever you choose to call it. Former Secretary of State Cyrus Vance warned the United States in a speech to the 1980 graduating class at Harvard University that the relationship between our country and the rest of the world has changed. We no longer are the all-powerful shot-caller who can get his way by economic pressures on our allies, enemies, and others. The "third world" countries—puny though they may be—are flexing some kind of muscle (as in Iran) and the giant appears paretic. This is not unlike the doctor and the third party payers and the army of allied health personnel who now serve the hospitalized patient. The United States must recognize a new order of priorities and new international relationships or we will go down the proverbial drain. Likewise, the physician must acknowledge—and accept—the new order of things in the dispensation of health services in the hospital setting.

In the final analysis, it's the patient who counts the most.

He chooses the physician—and fires him if he wishes. He accepts or rejects suggestions as to studies, surgery, or treatments. He may fill your prescription, but not take all the pills. She may accept your diet list, but not necessarily follow it. Despite all the professional buttinskies, however, the patient still looks first and last to the *physician* for advice and counsel, for accurate diagnosis, and effective therapy.

The old ballgame is over, but it is now the first inning of the second game of a double header. We have to learn from the past and from the present, and *we* have to change.

So, what shall we do? Consider the following:

1. Maintain a high-level self-image as the director of your patient's health care program.
2. Recognize the new role for the patient as the key member of the health care team.
3. Hone your skills and knowledge to the sharpest edge possible, and seek consultation in matters beyond your ken.
4. Accept the third world of medical care—our allied professionals—who have much skill and knowledge which can help our patients.

It is true—the ballgame is over! But, a new game has started.

A.K.

Medical School Affiliation

To affiliate with New Jersey or out-of-state medical schools? That is the question!

In the past, New Jersey medical centers have played "second fiddle" to the hospitals and medical schools of New York City and Philadelphia. With the advent of the medical schools in New Jersey, and the socioeconomic problems of New York City and Philadelphia, coupled with the exodus of well-trained physicians to New Jersey and the rapid growth of numerous teaching affiliated hospitals in New Jersey, the "second fiddle" is on the verge of becoming "first fiddle." However, the medical schools in New York City and Philadelphia have developed attractive affiliated programs with some of our finest hospitals in New Jersey. These programs recently have been effective in restoring Morristown Hospital with Columbia University Medical School, to its best intern match in years. Overlook Hospital, another Columbia affiliate, also matched fully, as did Monmouth Medical Center, a Hahnemann Medical School affiliate, with completely matched interns.

On the other hand, the New Jersey Medical School affiliates have not matched completely, although Saint Michael's Medical Center came close to a complete match with 13/16, with predominantly American medical school graduates. Yet, the New Jersey Medical School matched 38 positions, and Rutgers' affiliated programs matched 12 of 18 positions.

Thus, the mother institutions did fairly well, but have never helped their affiliated hospital programs per se, as out-of-state schools have done. Those programs that have cast their fortunes with an out-of-state school have said the following:

1. Out-of-state schools have better ratings and assist in recruiting interns.
2. They do not compete locally with New Jersey medical schools for the same pool of interns.
3. Out-of-state schools do not try to control local affiliates, but treat affiliates with respect and dignity.
4. Out-of-state schools are better organized and more experienced with affiliates.
5. The New York City and Philadelphia schools hope to maintain their "tertiary" care-referral pattern and their patient referrals. This is their motivating factor.
6. Students are encouraged to rotate with affiliates.

Those who favor New Jersey schools do so for:

1. Convenience.
2. Altruistic reasons to foster state medicine.
3. Support of per diem hospital rates from the schools and from the presidents of medical schools.
4. Close visiting faculty.

In actuality, the New Jersey medical schools, which have been slow in granting faculty appointments to the affiliated hospital faculty, will not send third-year students in medicine to the affiliated hospitals when the residency program is not part of the integrated residency, such as the East Orange VA Hospital, University Hospital, Newark Beth Israel Medical Center, and Saint Michael's Medical Center. Fourth-year and intern applicants are discouraged from going to CMDNJ affiliated hospitals, in hope of keeping these students at the University Hospital. As a result, superb programs like St. Barnabas Medical Center's Obstetrics and Gynecology, with a Jefferson Medical College affiliation, have achieved a greater degree of excellence than any in the State of New Jersey. Loyal affiliates in New Jersey are treated like second-class citizens, as the New Jersey medical schools are focusing on University Hospital's own needs, rather than on the needs of the unmanageably large number of affiliates.

The New Jersey medical schools were the first to challenge the "second fiddle" role in medicine for New Jersey. Now, they are, by design or complacency, or just a supreme desire to control, opening up the doors to New York City and Philadelphia, to restore their own previous preeminence.

Wake up, New Jersey, before it is too late!

Anon.

The New Chairman of the Board

WILLIAM GREIFINGER, M.D.

William Greifinger, M.D., of Belleville, a Diplomate of the American Board of Internal Medicine and Fellow of the American College of Physicians, has been elected Chairman of the Board of Trustees of the Medical Society of New Jersey. He has been a member of the Board since 1974. His brother, Marcus Greifinger, M.D., had served as Secretary of the Society for many years.

Dr. Greifinger earned his Bachelor of Arts degree from the University of Pennsylvania and graduated from the University of Maryland School of Medicine in 1936. He served in the United States Army Medical Corps during World War II, attaining the rank of Major.

He has been the Medical Director at Clara Maass Memorial Hospital, Belleville for eleven years and a member of that hospital's medical staff for over forty years, having served as Director of the Department of Medicine and President of the Medical Staff. Along with his activities at Clara Maass Memorial Hospital, Dr. Greifinger has been President of the Essex County Medical Society and is a former Director of Medicine and President of the Medical Staff at St. James Hospital, Newark, where he currently is Vice President of the Board of Trustees. He was also Medical Director of the Newark Board of Education.

Dr. Greifinger and his wife, Gertrude, reside in South Orange, New Jersey. Their sons, Robert Greifinger, M.D. and David Greifinger, M.D., are graduates of the University of Maryland School of Medicine; their third son, Richard, was graduated from Seton Hall Law School and has been admitted to the Bar.

A special tribute recently was presented to Dr. Greifinger by the Clara Maass Memorial Hospital Guild when he was named the recipient of their first annual "Physician of the Year" award. He was cited for his humanitarian and educational work in the medical profession. The tribute explained: "His rare moments when medical matters do not intrude are devoted to his family. As is well known by all who are fortunate to count him as a friend, he is a very special person of warmth, compassion, and humor. He cares about people and is always willing to counsel, to arbitrate, to console, and to encourage. His door stays open to all who seek his help."

JEMPAC New Jersey Medical Political Action Committee

JEMPAC REPORTORIAL

HINTS FOR EFFECTIVE COMMUNICATION WITH LEGISLATORS

Members of Congress and State legislators pay attention to their mail. They have to, because the writers' views form a major listening post for voter sentiment on pending legislation. The following hints can aid you in being effective in communication with your legislator.

Form letters and petitions have little effect. Form letters with identical wording, long telegrams signed by lists of people, mimeographed petitions and other "bulk" entreaties carry little or no weight. The legislators know from experience that sudden outpourings, with suspicious similarity, are largely from disinterested persons who are goaded into signing a form letter or petition by some lobbyist or political action group.

Be yourself and write your own letter. It is the carefully thought-out individual letter that a law-maker appreciates. Set forth exactly why you consider a bill good or bad, how you feel it would affect you and your community.

Always be courteous. Threats, warnings, and abuse merely antagonize elected officials. Effective mail is courteous and the recipient is well aware, without reminding him in a letter, that he may be your "second favorite" candidate in the next election if he lets you down.

Write when you are pleased. If you are pleased with a legislator's position on a bill or with his vote, write to thank and compliment him on his stand. This is important. Letters for a job well done are altogether too rare.

And follow through. Almost all office holders answer their mail, but if your reply is just a brief acknowledgement, write again to ask for more specific information, e.g., precisely how he stands on the issue, how he feels toward its success.

Timing can be vital. Another important factor is *when* you send your letter. A deluge of mail just as a measure is about to be voted on is much less effective than a single intelligent letter months before while the legislator is still formulating his opinions. When possible, always refer to the bill under discussion by its name and number.

MSNJ'S POSITION ON PROPOSED NJ LEGISLATION

Senate-746—Joseph Hirkala (34th District part of Passaic) To make information given to certain peer review committees confidential and to extend immunity to members of medical audit, mortality and peer review committees of hospital and long-term care facilities. **ACTIVE SUPPORT**

Senate-747—Joseph Hirkala (34th District part of Passaic). To exempt from civil liability members of the governing body of a hospital for any decision concerning the appointment or removal of a physician if reasonable and without malice. **ACTIVE SUPPORT**

S-746 and S-747 assigned to:

Institutions, Health and Welfare Committee:
Anthony Scardino, Chairman, William J. Hamilton, Vice-Chairman, Anthony E. Russo, Garrett Hagedorn, James P. Vreeland.

Assembly-423—Alan Karcher (19th District part of Middlesex). To provide immunity from law suits for medical audit, tissue and mortality review committees established by hospitals. **ACTIVE SUPPORT**

Assigned to:

Judiciary, Law, Public Safety and Defense Committee:
Martin A. Herman, Chairman, William J. Bate, Vice-Chairman, John Paul Doyle, Eugene J. Thompson, William E. Dowd, William L. Gormley, Walter M.D. Kern, Jr.

*The *JEMPAC REPORTORIAL* will be a monthly feature designed to inform members of MSNJ of PAC activities and to report issues of mutual concern. It is hoped this will heighten physician awareness of the need for participation in the political process. This item from JEMPAC was prepared by Frank Watson, M.D., and A. Ronald Rouse, who are, respectively, Chairman of the Committee and Executive Director and Editor.

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Long-Term Care Placement in the New Jersey Medicaid Program

DONALD MALAFRONTE, HOWARD M. MOSES,
CAROL K. BERLIN, East Orange*

A study of 1,250 long-term care Medicaid cases was conducted to determine how many patients could be discharged if appropriate alternative settings and services were available. The study found that 35 percent of those currently institutionalized at the IV(B) intermediate care level could be discharged if such settings and services were available. Of those recommended for discharge, 72 percent required congregate living arrangements.

The Urban Health Institute, in cooperation with the New Jersey Medicaid Program, studied a sample of cases from the category of long-term care classified in New Jersey as IV(B), an intermediate level of care that provides minimal nursing services and residential services to those for whom life in the community is judged impractical but who are not sick enough to require skilled or a higher level of intermediate nursing services. New Jersey regulations describe such patients as ambulant or semi-ambulant with physical and/or mental dysfunctions requiring minimal assistance with personal care needs on a daily basis. Level IV(B) is the lowest level of long-term care covered by Medicaid. It was selected for examination because by definition IV(B) patients are closest to the need for alternative care and most likely to provide accurate indicators of the types of alternative settings and services required in New Jersey.

Other levels of long-term care in New Jersey are Level III, which involves skilled nursing care for persons with acute or sub-acute medical or mental dysfunctions requiring continuous skilled nursing care, and Level IV(A), the upper level companion to IV(B). Upper Level IV(A) patients are judged to require *substantial* assistance with personal care needs on a daily basis rather than the *minimal* assistance required in IV(B). Category IV(B) is relatively new, having been established in 1974.

Most IV(B) patients are elderly and in nursing homes, while a minority are in special hospitals or other types of long-term care institutions. The classifications used for analysis in this study are those of the New Jersey State Department of Health, which licenses such facilities. Medicaid does not distinguish among classifications of facilities offering long-term care.

This study was concerned with only one aspect of Medicaid: its institutionalized, long-term care patients and the question of how many could live more independently, if appropriate alternative settings and services were available. Financial eligibility and reimbursement policies which might affect placement were not included in the study.

STUDY METHODOLOGY

In conducting the study, eight local Medicaid offices were selected randomly from among the 16 in New Jersey. Local office medical evaluation teams, consisting of a physician, nurse and social worker, completed an Institute questionnaire concerning their perceptions of every case reviewed for recertification during a three-month period. The social worker was utilized by Medicaid as a team member for the duration of the study. Normally, a social worker participates only in initial assessments, cases of prospective denials of benefits and in cases involving special problems. The teams are responsible for certifying the level of long-term care

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required, if any, and periodically reevaluating need and quality of care rendered to the patient. Objectivity might have been enhanced by independent team reviews or cross-district reviews, but these approaches were judged unacceptable by the participating State and local Medicaid offices. As a result, the Institute increased the size of the sample and doubled the number of participating districts to assure a higher degree of statistical probability for study findings.

The eight offices were Bergen, Burlington, Camden, Essex, Hudson, Hunterdon—which includes Hunterdon, Warren and Somerset Counties—Mercer and Middlesex. The sample offices included 96 licensed facilities serving IV(B) patients: 70 nursing homes; 15 incorporated homes for the aged, virtually identical to nursing homes; four licensed as intermediate care facilities; and seven general and special hospitals. The classifications are those of the State Department of Health, which licenses such facilities. All are approved by Medicaid to offer an intermediate level of care.

Preliminary questionnaires were developed and pretested during a three-week trial period in the Mercer office. Institute staff was present at each conference during the trial period to observe team reactions to the survey instrument and to note difficulties in either question interpretation or question completion. As a result of the pretesting, a number of changes in the questionnaire were made.

The medical evaluation teams began utilizing the final study questionnaire in the eight sample offices in May, 1976. Institute staff members were present at all conferences held during the first two weeks at each office to observe the teams at work. A third week was spent with those teams that were judged to require additional observation.

The study continued for a three-month period, selected to permit the sampling of approximately 50 percent of all IV(B) residents in the eight offices. Since each IV(B) resident is reviewed every six months, approximately half of the total residents are reviewed in any three-month period. Cases reviewed numbered 1,250, a sample of 25 percent of all cases in the IV(B) category. The sample size produced a statistical probability of 97 percent for its findings to be true for all IV(B) cases.

The questionnaires were gathered by the local administrators in each local office. They labeled each questionnaire with an identification number to protect confidentiality of records and forwarded the questionnaires bearing only the number to the Institute for processing.

FINDINGS

Percent Appropriate for Discharge—An average of 35 percent of those studied were judged suitable for discharge if appropriate alternative settings and services were available.

There was considerable variation in recommendation for release among the offices, from a low of 16.9 percent in Hudson to a high of 79.8 percent in Burlington. The Institute believes the variations were attributable in large part to observational bias, differences in training and other team and office considerations, rather than significant differences in patient populations. For example, in those offices with the largest caseloads for review, the proportion of patients which was recommended for alternative care was the lowest. In those offices with the smallest caseloads, the proportion of patients which were recommended for alternative care tended to be highest. Similarly, those offices in urban areas tended to find fewer patients suitable for discharge than those districts serving rural areas. Table 1 shows the rank order of the offices in terms of the size of the caseload under review and summarizes the recommendations in each office.

"The study found that 35 percent of those currently institutionalized at the IV(B) intermediate care level could be discharged if such settings and services were available."

In the Hudson office, 248 cases were reviewed during the study period. This was the largest caseload among the sample offices. Of these, only 42 patients were recommended for alternative care, representing 16.9 percent of the cases reviewed.

By contrast, the Camden office had the smallest caseload among the sample offices. Of the 94 cases under review in Camden during the study period, more than half of the patients—51.1 percent—were recommended for alternative care. However, in the neighboring Burlington office, with 104 cases under review, 83 patients, or 79.8 percent, were recommended for alternative care. Burlington services a less urban area than Camden.

In the Mercer office where the survey instrument had been pretested during March, 1976, the proportion of patients recommended for alternative care and continued institutionalization most closely approximated the average for the eight study offices. Of 100 cases reviewed in the Mercer office, 33 patients, or 33 percent, were recommended for alternative care, compared with 35 percent for the total sample.

Recommended Settings—The medical evaluation team held that 72 percent of those patients recommended for alternative care—or 25 percent of all IV(B) patients—could be cared for in alternative, congregate living arrangements.

For all patients who were recommended for alternative care, the medical evaluation teams were asked to make a finding as to the kind of setting which, if available in the community, could serve as an appropriate supportive environment for the patient. Five settings were included as possible alternatives to continued institutionalization: independent living; living with family; foster home; boarding home providing personal services beyond food, shelter and laundry; and sheltered care which, in this study, was intended to describe an establishment providing the services of a boarding home and some additional professional services such as nursing and home health services. Boarding home and sheltered care as described are congregate living arrangements which are presumed to be somewhat more like a home than the institutions currently housing the Level IV(B) population and, presumably, less expensive facilities to operate.

Of the 437 patients who received recommendations for alternative care, 72.1 percent required some variety of congregate living arrangement. For 27.9 percent, a home environment, either independently with their own families or in a foster home arrangement, was considered appropriate.

The data show wide variation among offices as to the recommended settings. In the Hunterdon office, the medical evaluation team found that 87.0 percent of the patients recommended for alternative care required a congregate

Table 1

Case Recommendations by Local Office, Ranked by Number of Cases Reviewed, Level IV(B) Patients, New Jersey 1976

Rank	Cases Reviewed: Office	Cases Reviewed: Number	Recommendations: Alternative Care: Number	Recommendations: Alternative Care: Percent	Recommendations: Continued Institutionalization: Number	Recommendations: Continued Institutionalization: Percent
1	Hudson	248	42	16.9	206	83.1
2	Bergen	215	51	23.7	164	76.3
3	Essex	215	61	28.4	154	71.6
4	Middlesex[1]	161	65	40.4	96	59.6
5	Hunterdon	113	54	47.8	59	52.2
6	Burlington	104	83	.79.8	21	20.2
7	Mercer	100	33	33.0	67	67.0
8	Comden	94	48	51.1	46	48.9
	Total	1,250	437	35.0	813	65.0

[1]Comprises Hunterdon, Worren ond Somerset Counties. In oll other instonces, the district boundories and county lines ore coterminous.

Table 2

Level IV(B) Cases Recommended for Alternative Care by Local Office and Recommended Setting, New Jersey, 1976

	All Coses[1]	Recommended Setting: Home: Total		Home: Independent Living		Home: Family Living: Own Fomily Only		Home: Family Living: Foster Home		Congregote Living: Total		Congregote Living: With Personol Core Only		Congregote Living: With Personal Care ond Professional Services	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Bergen	51	12	23.5	1	2.0	10	19.6	1	2.0	39	76.5	22	43.1	17	33.3
Burlington	83	13	15.7	5	6.0	3	3.6	5	6.0	70	84.3	5	6.0	65	78.3
Camden	48	10	20.8	2	4.2	1	2.1	7	14.6	38	79.2	24	50.0	14	29.2
Essex	61	24	39.3	3	4.9	4	6.6	17	27.9	37	60.6	16	26.2	21	34.4
Hudson	42	14	33.3	--	--	14	33.3	--	--	28	66.7	21	50.0	7	16.7
Hunterdon	54	7	13.0	--	--	1	1.8	6	11.1	47	87.0	17	31.5	30	55.6
Mercer	33	30	90.9	1	3.0	4	12.1	25	75.8	3	9.1	1	3.0	2	6.1
Middlesex	65	12	18.5	2	3.1	3	4.6	7	10.8	53	81.5	29	44.6	24	36.9
Total	437	122	27.9	14	3.2	40	9.2	68	15.6	315	72.1	135	30.9	180	41.2

[1] All coses recommended for alternotive care.

living arrangement while the needs of only 13.0 percent could be met in a home environment. By contrast, in the Mercer office, the medical evaluation team found that only three patients—9.1 percent—of those recommended for alternative care required a congregate living arrangement whereas 30 cases—90.9 percent—could have their setting needs met in a home environment.

Of the 122 patients who received recommendations for alternative care in a home environment, 68 patients—5.4 percent of all IV(B) patients sampled—were said to require a foster home setting. An additional 40 patients—3.2 percent of all IV(B) patients sampled—were found to require family living with their own families. Independent living, i.e., living alone in one's own home, was found to be an appropriate recommendation in 14 cases—one percent of all IV(B) patients sampled—if certain home services were available.

Among the 315 patients who were recommended for congregate living arrangements, 180 patients—14.4 percent of all IV(B) patients sampled—were said to require a congregate living arrangement providing room, board, laundry and some additional professional services such as nursing or home health services. An additional 135 patients—10.8 percent of all IV(B) patients sampled—were found to require the services of a facility providing personal care services only.

Table 2 shows recommended settings for those patients who could be released, with detail on the kind of home environment recommended and on the kind of congregate living arrangement recommended.

Service Needs—Most IV(B) patients recommended for release need one or more of four categories of nursing and other supportive services.

In addition to making a finding regarding the appropriate alternative setting for patients who were recommended for alternative care, the medical evaluation teams made recommendations regarding the kinds of supplementary services which would be required for IV(B) patients recommended for alternative care.

Four supplementary services were considered potentially available: nursing services, home health aide/homemaker services; therapeutic services, including physical, speech and recreational therapies as well as psychosocial counseling, and other support services, including transportation, telephone reassurance and similar services. Supplementary nursing services and home health aide/homemaker services would

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"The 1,700 beds which would become available . . . are sufficient in number to accommodate most of the 1,500 to 2,000 persons estimated by Medicaid to have been awaiting placement . . ."

not be required by patients placed in a sheltered care environment since sheltered care was defined so as to include provision for these services.

Among the 437 patients who were recommended for alternative care, 315 patients, or 72.1 percent, were found to require services not normally provided in the setting to which they were recommended.

In order to facilitate understanding of the implications of these findings on the total need for community-based support services adequate to permit discharge of patients to alternative settings, estimates have been made of the total number of IV(B) patients requiring additional services. For example, the 315 patients who would require supplementary services in alternative care settings represent 25.2 percent of the entire IV(B) population sampled. Therefore, supplementary services would be required by 25.2 percent of all IV(B) patients in order to permit relocation of 35 percent of all IV(B) patients.

Table 3 shows the needed supplementary services specified by the medical evaluation teams and the percentage of all IV(B) patients who would require those services if appropriately placed.

A total of 69 patients—5.5 percent of all IV(B) patients—were found to require no additional services if they were placed in more appropriate environments. Of the 437 patients recommended for alternative care, 135 patients—10.8 percent of all IV(B) patients—would require nursing services not provided in the setting in which they live. Support services would be required by 146 patients—11.7 percent of all IV(B) patients. Therapy would be required by 109 patients —8.7 percent of all IV(B) patients—of those recommended for alternative care while home health aide/homemaker services would be required for only 61 patients—4.9 percent of all IV(B) patients.

Applying these percentages to the entire Level IV(B) population of the state (4,920 patients), an estimate was derived of the total services required to enable 35 percent of all IV(B) patients to be placed in accordance with the recommendations of the medical evaluation teams. In order to appropriately place 35 percent of all Level IV(B) patients in the state, sufficient licensed nursing services would be required for 532 patients. Home health aide/homemaker services would be required by 428 patients and other support services would be required by 576 patients. The estimates are totals for each category. Some patients would require two or more of these services.

In addition to recommending appropriate services, the medical evaluation teams indicated that 158—12.6 percent—of those recommended for alternative care could benefit from participation in an adult, day-care program. Application of the total percent of Level IV(B) residents requiring day care results in an estimate of 620 patients who, if appropriately placed would need day-care services statewide.

DISCUSSION

Impact on Long-Term Care Cost and Bed Need—The percentage of IV(B) patients who could be discharged if appropriate alternative settings and services were available is significant in terms of the number of patients involved and the cost of their care. The percentage is also significant in terms of the number of beds which could be made available to others presently awaiting appropriate placement and in reducing the need for costly construction or conversion to produce additional long-term care beds.

Projected for the entire IV(B) population, the study findings indicated that more than 1,700 persons could be placed in more appropriate lower levels of care. The annual cost of this care for these persons in their institutional setting at the time of the study amounted to more than $10 million. In 1980, the cost will be closer to $20 million.

The 1,700 beds which would become available through more appropriate placement constitute nearly 11 percent of all long-term care beds in New Jersey and are sufficient in number to accommodate most of the 1,500 to 2,000 persons estimated by Medicaid to have been awaiting placement in New Jersey at the time of the study. The cost of adding 1,700

Table 3
Service Needs of Level IV(B) Patients, New Jersey, 1976

Service	Number of Sample Persons Requiring Services	Percent: Of Patients Recommended for Alternative Care	Percent: of All IV (B) Patients	Estimated Number of all IV (B) Patients in New Jersey Requiring Services
Licensed Nursing	135	30.9	10.8	532
Home Health Aide/ Homemaker	61	14.0	4.9	242
Therapeutic Services	109	24.9	8.7	428
Other Support Service	146	33.4	11.7	576
None	69	15.8	5.5	n/a

beds through new construction was judged at the time of the study to be approximately $28 million, using a conservative construction estimate of $17,000 per bed, based on then-current surveys of nursing home construction in the New York-New Jersey area. The cost in 1979 was closer to $30,000 per bed, indicating a total construction cost of some $40 million.

The high percentage of IV(B) patients who can be moved to a lower level of care, combined with the underutilization of many acute care hospitals in the state that could be utilized to offer services to patients in need of higher skilled care suggest that coordinated planning could produce sufficient long-term care beds to meet New Jersey's present needs without additional construction. Nothing has occurred since the study to change the Institute's perception.

These conclusions are based on findings regarding the physical and mental condition of patients and do not take into account financial eligibility and reimbursement policies which tend to favor institutionalization and therefore stand in the way of simple, direct transfer of patients to more appropriate, alternative care.

Feasibility of Independent Living—Independent living was not considered a viable alternative for IV(B) patients. Only 14 of the 437 persons recommended for discharge were judged capable of fully independent living. This represented about three percent of those recommended for alternative care and just one percent of all those studied. The only alternatives judged practical involved lower levels of care which tended to blur the difference between institutional and non-institutional care.

Congregate Living—The setting most recommended for those who could be released—some form of congregate living arrangement—suggested a need for either a lower level of institutional care or a higher level of community care, neither of which was judged to be available.

While the description of the most frequently recommended setting appeared similar to that used by the State Department of Health to define a sheltered boarding home, the area remains, as it has for some years in long-term care, a gray zone, ranging from something more than room, board and some personal services at the boarding home level to something less than 24-hour per day nursing care and other professional services at the nursing home level.

Community-Based Services—The services which could be required to facilitate more appropriate placement of IV(B) patients are the type which could be provided at the community level.

In order to facilitate appropriate placement among all IV(B) patients, the study finding projected that it would be necessary to provide community-based licensed nursing services for about 530 people. Home health aide/homemaker services would be required by about 240 people. This does not include provision for nursing services and home health aide/homemaker services for those 180 persons recommended for congregate living arrangements with professional services since, by definition, those services would be available routinely in the setting itself. These estimates are of the volume of services which would be required by persons no longer institutionalized in settings providing the service.

In addition, a variety of therapeutic services would be required by about 425 people while communication/transportation and similar support services would be required by 576 people. In addition, day-care services would be required for approximately 620 people.

"... coordinated planning could produce sufficient long-term care beds to meet New Jersey's present needs without additional construction."

Continued Institutionalization—At least 65 percent of IV(B) patients must continue to remain in intermediate care facilities and improvement in the quality of their lives is dependent on the ability of institutions to respond effectively to their human needs.

Even if the support of alternative care is adopted as a major policy, many patients must remain institutionalized and this will continue to be so, during any period of change and after it. A parallel movement for humanistic care within institutions is a logical, linked step. The focus of this movement most likely will be on the psychosocial aspects of institutionalization, rather than on medical and custodial services.

CONCLUSION

Decisions regarding alternative care and deinstitutionalization have issues at their core larger than medical decisions and Medicaid policy. They center on beliefs (independent living is more desirable and possibly even healthier); fears (we are getting older and we don't want to end up that way); desires to help (let's do something for the needy and the aged); and human inpulse to grow (let's change things). In addition there is public pressure upon government to stabilize health care costs. This often has been translated in regard to long-term care as pressure to get people out of nursing homes in order to save money. In fact, although the human factors associated with deinstitutionalization are rarely disputed, cost factors are unclear. Involved at the least are significant money and other cost transfers. Many money costs presently borne by Medicaid could be transferred to other programs, presumably also publicly financed, to support the increased need for alternative care services. For example, the cost of care to Medicaid for the 35 percent of patients recommended for alternative care was more than $11 million in 1976. Today the cost is closer to $20 million. However, rather than transferring the money elsewhere, Medicaid's role could instead be recast, leaving it to utilize its funds to become as pertinent a force in alternative care and deinstitutionalization as it is today in supporting long-term institutional care.

It is recommended that Medicaid adopt the development of alternative care resources as a long-term care policy; that the availability of alternative care resources in New Jersey be inventoried; that reimbursement practices which encourage deinstitutionalization be tested; that the training of medical evaluation teams be reviewed and redesigned to encourage more consistent assessments among offices; and that the present pressure for new long-term care beds be met by coordinated, inter-agency planning which takes into consideration (1) the high percentage of long-term care patients who can benefit from alternative care and (2) the current oversupply of acute care beds in general hospitals.

SUMMARY

The Urban Health Institute, in cooperation with the New Jersey Medicaid Program, studied 1,250 long-term care Medicaid cases drawn from eight districts in New Jersey to determine how many patients could be discharged if appropriate alternative settings and services were available. The cases were drawn from the level IV(B) category, an intermediate level of care that provides residential services, and minimal nursing care to those for whom life in the community is judged impractical but who are not sick enough to require skilled or a higher level of intermediate or skilled nursing services. The study found that an average of 35 percent of those studied could be discharged if appropriate settings and services were available, although recommendations for discharge varied widely among districts. The study also found that 72 percent of those recommended for release required congregate living arrangements. The percentage of IV(B) patients who could be discharged suggests that Medicaid should support active development of alternative care resources as a major long-term care policy.

Personalizing the Risk of Cigarette Smoking*

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To enhance the impact of anti-smoking messages, it is important to help smokers personalize the threat to their health which smoking presents. This article discusses four specific techniques to help accomplish that aim. They are use of carbon monoxide measurements in expired air, spirometry, external filters, and the concept of high-risk smoking.

The Surgeon General's conclusion that cigarette smoking is harmful to health has been supported by overwhelming evidence.[1] In 1964, the Report of the Advisory Committee on Smoking and Health drew upon data from about 6,000 articles in the world literature on smoking and health. Over 30,000 such articles were available for preparation of the Surgeon General's Report in 1979.[2] The association between cigarette smoking and lung cancer, emphysema, and heart disease now is firmly documented.[2] Cigarette smoking also plays an important role in the etiology of peptic ulcer, infancy respiratory disease, noncancerous oral disease, and cancer of the larynx, oral cavity, esophagus, urinary bladder, and pancreas. [3]

The harmful effects of cigarette smoking yield a staggering economic impact.[4] Luce and Schweitzer estimated the economic cost of tobacco abuse in the United States alone in 1975 to be 41.5 billion dollars.[3] It is unlikely that 1979-1980 estimates would be any lower. The increasing rate of smoking among young women and the growing number of women suffering the ill effects of cigarette smoking suggest that the public health and economic impact of cigarette smoking is increasing.[5,6]

Despite these rather alarming findings, approximately 45 million adults continue to smoke in the United States alone, and young people, particularly young girls, are acquiring the smoking habit at an increasing rate.[7,8] Can so many adults be uninformed about the harmful effects of cigarette smoking? Can our young people similarly be so naive? Very likely, today's smokers are aware of the harmful effects of cigarettes on the body. The warning by the Surgeon General is present on each and every pack of cigarettes, and the news media contain more and more reports of the relationship between cigarette smoking and ill health than ever before.

While it is likely that health education campaigns have influenced many adults to stop smoking and prevented many young people from starting, health messages and fear-arousing warnings too often fall upon "deaf ears" and too readily trigger any one of a number of denial mechanisms on the part of the smoker. It is one thing to comprehend the data on an intellectual level and quite another to personalize the significance of the message. Few people can appreciate fully their own mortality, and it is too easy to rationalize that cancer is something that will strike other cigarette smokers—"not me."

During the past five years, I have had considerable contact with smokers and the issue of the personalization of risk. Activities at the Medical School in Newark include research studies as well as the supervision and conduct of a variety of smoking cessation programs. The purpose of this article is to share some of the strategies and techniques which have been

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Table 1
Carbon Monoxide (CO) Levels of Participants in a Quit-Smoking Group

	Session Number					
	1		4		8	
Participant	Cig./Day	CO (ppm)	Cig./Day	CO (ppm)	Cig./Day	CO (ppm)
1	25	40	15	22	10	5
2	60	36	25	30	0	1
3	20	20	1	5	0	1
4	40	22	15	15	0	1
5	40	23	30	24	40	25
6	25	33	10	19	5	10
7	25	24	4	15	0	1
8	40	22	21	19	0	1
9	30	33	12	35	30	33
10	20	43	20	43	0	1

developed specifically to aid smokers in the process of personalizing risk and relating to the potential effects of cigarette smoking on their health. While it is important to note that sucessful smoking cessation and prevention programs must go far beyond the issue of smoking and health, the personalization of risk very well may be a major contributor to the ultimate success of the anti-smoking effort. Certainly, the techniques and strategies discussed below may be viewed as important adjuncts to treatment. Moreover, they also may play an important role in maintaining the smoker's behavior change once formal treatment is terminated.

EXPIRED-AIR CARBON MONOXIDE MEASUREMENT

One of the more harmful substances to which smokers are exposed is carbon monoxide.[9] This poisonous gas enhances the smoker's risk of coronary heart disease and is a major source of "second-hand" smoke. Apparatus is available at fairly modest prices which can be used to measure the amount of carbon monoxide in a smoker's expired air.[10] Typically, smokers yield measurements of 20 and 30 ppm or more, depending on the number of cigarettes smoked per day, brand of cigarettes, time since smoking the last cigarette, and inhalation patterns (e.g., deep chest, part chest). Nonsmokers and ex-smokers rarely yield measurements of more than five ppm.

Carbon monoxide measurement, then, represents an important way of demonstrating to the smoker, male or female, young or old, that cigarette smoking has an immediate and substantial effect on the body. Stopping smoking or simply cutting down, on the other hand, may contribute to a reduction in carbon monoxide exposure—not years later but within hours. Table 1 shows some carbon monoxide measurements obtained in a recent community smoking clinic sponsored by the Essex County Heart Association.

The table shows for each participant in the clinic the number of cigarettes smoked per day and the associated carbon monoxide reading for Sessions 1, 4 and 8. The initial intervention phase of the clinic terminated after Session 8. However, periodic reunion and booster sessions are scheduled to help the participants maintain their changes and gains.

Several findings are noteworthy. All of the adults attending the clinic had excessive carbon monoxide readings at the start of the clinic. As they reduced the number of cigarettes they smoked per day, the carbon monoxide reading decreased. This served as useful "biofeedback" and also as an objective measure of reported changes in smoking.[10] At Session 8, six of the ten smokers reported total cessation while two others achieved a substantial reduction in cigarette smoking. In all cases, marked reductions in carbon monoxide exposure were found. For the two participants who made little, if any, smoking changes, the carbon monoxide remained elevated. To be sure, additional carbon monoxide measurements shall remain an integral feature of the follow-up maintenance sessions.

SPIROMETRY: SMALL AIRWAY DISEASE

Small airway disease refers to pulmonary pathology which may or may not be accompanied by respiratory symptoms.[11,12] Routine autopsy studies performed on youthful victims of sudden or unexpected death revealed that loss of bronchial epithelium and evidence of bronchial wall inflammation were common in those who smoked. The most striking abnormality was respiratory bronchiolitis, a lesion of the small airways found in all of the smokers and few of the nonsmokers. Edema, fibroses, and epithelial hyperplasia were seen commonly in the thin walls of small peripheral airways.[11]

Many cigarette smokers have normal pulmonary function when measured by conventional studies utilizing forced expiratory volume in one second and forced vital capacity, even though pathological studies on those who die accidentally show involvement of the small airways as mentioned above.[11] Two relatively new tests—closing volume and mid-maximal expiratory flow rate (MMER)—help to identify patients with small airway disease. The measurement of closing volume requires inhalation of an inert gas, such as argon, nitrogen, or even oxygen, and is based on the observation that certain airway segments appear to close at lower lung volumes. The MMER measures expiration flow at lower lung volumes when airway segments begin to close. See Dosman and Macklem for a recent discussion and review of the literature on small airway disease.[12]

A number of studies have shown a surprisingly high frequency of small airway disease in relatively asymptomatic smokers, and other studies demonstrated actual improvement in mid-maximal expiratory flow rates for persons who stopped smoking.[11,13] Table 2 presents MMER data for five subjects participating in a study now in progress under my supervision at the New Jersey Medical School.

Table 2 shows for each participant the number of cigarettes smoked per day, the carbon monoxide reading, the MMER, and the number of pulmonary symptoms (i.e., wheezing, cough, phlegm, and so on) checked by the subject at the initial visit to the clinic and at a visit approximately 14 months later (12 months after stopping smoking). One hundred and twenty-three adult smokers participated in this study; analysis of initial data revealed that approximately half had small airway disease at the onset of the study. Since the study still is in progress, only some preliminary observations are possible at this time.

As shown in Table 2, the preliminary findings for five quitters support the above-mentioned studies and demonstrate some improvement in the MMER following smoking cessation. Note also the marked reduction in carbon monoxide and pulmonary symptoms. That is, the ex-smokers actually feel better. They cough less, spit up less phlegm, wheeze less, and breathe easier. Such data are very useful adjuncts to smoking counseling. They enable participants to relate more clearly to the fact that cigarette smoking is, indeed, beginning to take its toll. However, it is not too late to alter this process, and, for those that do stop smoking, improvement in lung function and a reduction in pulmonary

Table 2
Mid-Maximal Expiratory Flow Rate, Pulmonary Symptoms, Carbon Monoxide, and Cigarettes Per Day for Smokers at Entry and at 12 Months Followup

	Entry				12 Months			
Participant	Cig./Day	CO (ppm)	MMER (liters/sec)	Symptoms	Cig./Day	CO (ppm)	MMER (liters/sec)	Symptoms
1	25	30	1.58	10	0	2	2.14	2
2	30	23	1.20	7	0	3	1.60	0
3	35	21	2.26	11	0	2	2.74	2
4	40	36	3.34	6	0	4	3.72	2
5	20	21	2.22	8	0	5	3.66	0

symptoms as well as carbon monoxide exposure serve as positive feedback which may help sustain the changes in smoking behavior.

EXTERNAL FILTERS

One useful way to demonstrate to smokers just how much potentially dangerous and toxic substances they inhale into their bodies whenever they smoke a cigarette is to ask them to use for a brief period of time a clear plastic external filter. The "One Step at a Time" is one such device which consists of a series of four filters, each possessing greater filtration capacity than the other. Even filter #1, the weakest filter, requires cleaning after every 5-10 cigarettes. Otherwise, the plastic filter is completely darkened by black material which otherwise would enter the body. Hence, these filters dramatically demonstrate to young students, as well as to adults, just how much foreign and harmful material they actually take into their lungs with each cigarette. It is doubtful that the filters alone will cause many people to stop smoking for any great length of time; however, they may serve as useful adjuncts to more comprehensive smoking therapy. Clearly, they represent another means of helping the smoker personalize the risk of smoking.

THE HIGH-RISK SMOKER

While there is no evidence that smoking is good for you, there is evidence that it may be worse for some people than for others. Some people, because of environmental or genetic factors, already may be at excessive risk for some disease. Cigarette smoking may interact with risk factors already present to increase their risk even more. That is what is meant by a high-risk smoker. Some examples of high-risk smokers are asbestos workers in the case of cancer, pregnant women in the case of fetal health and mortality, and persons with high blood pressure and elevated serum cholesterol in the case of coronary heart disease.[14-16] Of course, persons with disease, such as survivors of heart attacks, also may be classified as high-risk smokers.

In helping smokers to personalize the risk of cigarette smoking, it may be valuable to consider the patient's overall risk profile for a variety of diseases. While this requires tact and a considerable amount of sensitivity, such risk-factor counseling may lead to successful outcomes in the long run. The most successful and encouraging long-term smoking cessation outcome data in the literature derive from the Multiple Risk Factor Intervention Trial (MRFIT).[17-19] The MRFIT is a six-year heart attack prevention program involving 12,000 participants and 22 clinical centers (one each at the New Jersey Medical School and at the Rutgers Medical School). To be eligible for the trial, one had to be a male between the ages of 35 and 57, free of serious illness, and in the upper ten percent of coronary heart disease risk based on the Framingham risk score. Hence, participants enrolled in the trial had some combination of high blood pressure, high serum cholesterol, and cigarette smoking. Approximately two-thirds of the participants smoked cigarettes at entry.

The bulk of smoking intervention was accomplished in a group intervention framework in which all of the risk factors were dealt with simultaneously. This was accomplished in ten successive weekly sessions during the first few months of the program. Thereafter, a formal maintenance program was introduced for successful quitters and secondary intervention efforts were introduced for those who did not quit smoking. All participants in the Special Intervention groups returned to the clinical centers every four months for data collection and once per year for a physical examination. The "Usual Care" control group was referred to private physicians for care and asked to return to the center for a physical examination on a yearly basis. Since the study still is in progress, it is not possible to discuss differences between the performance of the usual care and the special care participants.

The smoking data for the special intervention group are noteworthy. After two years of the study, approximately 45 percent of the smokers quit smoking, and 60 percent of the initial quitters did not return to smoking.[19] These data compare quite favorably with the literature on smoking cessation which shows that in most cases, 60 to 80 percent of the quitters recidivated within three to six months following treatment.[20] At this point in time, it is not possible to say exactly what factors contributed to the success of the MRFIT smoking program. It is noteworthy that the program did emphasize the theme of the high-risk smoker. Audiovisual materials, physician involvement, psychological counseling, and a host of other activities reinforced the concept that it was particularly dangerous for MRFIT participants to smoke and highly advantageous for them to quit. Whether or not the emphasis upon the concept of the high-risk smoker contributed to the success of the MRFIT smoking cessation program, it is likely that MRFIT participants, more so than most smokers, were able to personalize the risk of smoking.

DISCUSSION

There is no question that smoking cessation and prevention efforts must do more than dwell upon the potential ills of smoking. Moreover, it may be counterproductive to alarm people needlessly. However, smoking is a major threat to health and this fact cannot be ignored, particularly during the initial phases of intervention when the decision to try to quit or not to smoke still hangs in the balance. To stop smoking and remain a nonsmoker for the rest of one's life requires a certain commitment and involvement. If one feels that smoking is a minor threat or no threat at all, it is doubtful that that person will try seriously to stop smoking or refrain from starting when the occasion arises. To the

extent that the smoker fully feels that cancer means him/her and not the other person, that he/she truly can personalize the message behind the Surgeon General's warning, the smoker is better able to make a commitment to change, to benefit from the behavior change program provided for him/her and to become an active member of the anti-smoking effort.

The techniques and procedures described above represent practical ways of helping smokers personalize their risk. The techniques may be used alone or in combination but must be viewed as useful adjuncts to more comprehensive smoking programs. The techniques do not require invasive procedures nor a great deal of professional supervision (except for interpretation of spirometry data, and other), and they readily may be put to use in a physician's office, school health education class, or a community "quit-smoking group." It is even possible to refer participants in "quit-smoking groups" to their private physicians for risk-factor analyses or to invite a nurse or technician to the group to measure blood pressure and serum cholesterol.

In addition to helping smokers personalize their risk of ill health, the procedures described above may help persons appreciate what they gained by stopping smoking. Repeat carbon monoxide measurement, small airway disease determinations, and recalculation of, say, heart disease risk scores may prove to be useful nonsmoking maintenance techniques. Again, these procedures are not designed to be used in a vacuum but as part of a systematic effort to help the ex-smoker actively combat recidivism.

SUMMARY

Too often, health messages and warnings concerning the harmful effects of cigarette smoking fall upon "deaf ears" or trigger anyone of a variety of denial mechanisms on the part of the smoker or potential smoker. While anti-smoking efforts must go beyond the issue of the health consequences of smoking, more effort should be devoted to helping smokers, young or old, personalize the messages and truly relate to the risks to which smoking exposes them. This represents one of the first steps of an anti-smoking effort and may contribute to the ultimate success of the total effort.

Four particular strategies have been used with considerable success by the author and readily may be applied in other settings. These include (1) the use of carbon monoxide measurement to demonstrate an immediate toxic effect of smoking; (2) spirometry to demonstrate possible present damage to the small airways of the lung; (3) clear plastic external filters to show the kinds of undesirable material smokers routinely inhale; and (4) use of the concept of the high-risk smoker to help individual smokers understand why it is particularly important for them to quit smoking. These procedures represent important adjuncts to intervention in the initial phases where the decision to quit is so important and in the final stages where the maintenance of nonsmoking behavior is so critical.

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Shoulder Pain as An Early Symptom of Pancoast Tumor

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Early diagnosis combined with pre-operative irradiation and radical surgery of apical lung tumors improves long-term survival.[1-3] Although difficult, this makes early diagnosis imperative. Pain in the shoulder radiating down the arm is a cardinal early symptom. Our patients illustrate delays in diagnosis due to this oversight.

Pain in the supraclavicular, scapular or shoulder region radiating into the arm is usually due to relatively benign conditions in the cervical spine or shoulder, but it may also be the harbinger of cancer of the thoracic inlet or superior sulcus.[4] In 1924, Pancoast described the symptom complex: "It produces referred nerve phenomena in the upper extremity which may be very misleading to the clinician and roentgenologist in their search for the cause."[5]

In spite of Pancoast's early exposition and more recent reminders, the syndrome too frequently is overlooked leading to long delays in diagnosis.[6-8] Patients often seek medical consultation in the initial stages because of shoulder pain but this frequently is dismissed by both the patient and the physician as arthritis or bursitis. This view may be reinforced by the difficulty in demonstrating any lesion in chest radiographs in the early stages. The value of searching for a Pancoast's tumor, even in the face of negative bronchoscopic findings, is illustrated in our patients (Tables I and II).

CASE REPORTS

Case 1—A 70-year-old man developed an aching pain in his left shoulder; it radiated down his left arm and gradually spread diffusely to his anterior chest wall and right shoulder. He was a very heavy smoker with a chronic cough. He first consulted a chiropractor, who instituted a course of manipulations of his left shoulder. During this therapy, he gradually became aware of increasing weakness of his left arm, numbness and paresthesia in his left hand and ptosis of his left eye.

When referred to a physician after a delay of 12 months, he was found to demonstrate all the classical signs of involvement of the left brachial plexus and cervical sympathetic ganglia. There was even a palpable mass in his left supraclavicular fossa. Chest x-rays at this time demonstrated an opacity at the left apex, with a possible lytic lesion of the first rib. A bone scan demonstrated an apical lung lesion with soft tissue metastatic disease in the left side of his neck. Bronchoscopy and bronchial washings both were negative, but exploration of the scalene fossa revealed infiltration of the brachial plexus and the first rib by tumor. Histological examination of the tissue from the scalene node and the first rib showed moderately well-differentiated adenocarcinoma. The tumor was considered inoperable due to the extent of the chest wall involvement, so he was given two courses of radiotherapy. He succumbed to brain and liver metastases ten months later.

Case 2—A 52-year-old female developed pain in her right shoulder and neck. She had a long history of chronic bronchitis and heavy cigarette consumption with recent onset of hemoptysis on occasion. She first consulted an

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Table I
Initial symptoms and diagnosis

Case	Age	Sex	First Service Consultent	Presenting Symptom	Cough	Cigarette Consumption	Initial Diagnosis
1	70	M	Chiropractor	Pain in left shoulder.	+ for years	++ for years	Arthritis
2	52	F	Orthopedist	Pain in right shoulder.	+ for years	++ for years	Bursitis
3	67	M	Int. Med.	Pain in right shoulder.	-----	-----	Arthritis
4	70	M	Int. Med.	Pain in right shoulder.	+ for years	++ for years	Arthritis
5	66	M	Family Physician	Pain in left shoulder.	+ for years	++ until 10 years ago	Pancoast Tumor

Table II
Physical manifestations developing before correct diagnosis made

Case	Age	Sex	Weight Loss	Later Physical Findings Before Correct Diagnosis				Time Lag before correct diagnosis
				Hemoptysis	Chest Signs	Horner's Syndrome	Sensory and Atrophic Changes	
1	70	M	–	–	–	+	Paresis, Hyperesthesia, Atrophic changes.	12 months
2	52	F	+	+	–	+	Paresis, Hyperesthesia, Atrophic changes.	6 months
3	67	M	++	–	Pleural Effusion	–	Paresis, Hyperesthesia, Atrophic changes	18 months
4	70	M	–	–	–	+	–	9 months
5	66	M	–	–	–	–	–	2 months

Table III
Investigations performed

Case	Age	Sex	X-ray of shoulder	Initial chest x-ray	Later chest x-ray	Bone Scan	Bronchoscopy and Sputum Cyto	Scalene Node Biopsy
1	70	M	Not Done	Not Done	Opacity in left apex	Apical lung lesion and neck metast.	–ve	+ve
2	52	F	Arthritic changes	Not Done	Right sulcus tumor	Not Done	–ve	+ve
3	67	M	Arthritic changes	Pleural Effusion	Apical tumor of R. lung	Not Done	–ve on two occasions	+ve
4	70	M	Nothing abnormal	Not Done	Thickening at R. apical cap	Nothing abnormal	–ve	+ve
5	66	M	Not Done	L. apical tumor	–	Not Done	Not Done	+ve

orthopedist and over the following six months visited several other doctors, all of whom prescribed various treatments for bursitis including injections of vitamin B_{12} and intra-articular cortisone.

Eventually, she showed signs of muscular weakness and was referred to a neurologist. Examination at this time showed marked weakness of her right arm with atrophy of the muscles, especially those innervated by the ulnar nerve. Hyperesthesia, hyperalgesia and atrophic skin changes were present. Ptosis, miosis, and anhydrosis of the right side of the face, dryness of her right hand, and increased perspiration of the left hand were noted.

A chest x-ray showed a right sulcus tumor. Bronchoscopy and bronchial washings were negative, but mediastinoscopy and scalene node biopsy revealed metastases of squamous cell carcinoma. The tumor was considered inoperable, so palliative cobalt therapy followed by chemotherapy were prescribed. Multiple metastatic lytic bone lesions gradually developed followed by signs of superior vena caval compression and recurrent laryngeal nerve paralysis. She died six months after the correct diagnosis was established.

Case 3—A 67-year-old man complained of pain in his right shoulder and initially was treated for arthritis of the shoulder and cervical spine. A chest x-ray taken later showed right pleural effusion. A nonsmoker, he gave no history of cough, but admitted to some weight loss. The effusion was tapped but cytology apparently was not requested. The patient was informed that he had a scar on his lung and was discharged. He was readmitted to the hospital two months later; bronschoscopy and mediastinoscopy were performed on two occasions with negative results. The patient was reassured, but followup chest x-ray demonstrated a tumor in the right

pulmonary apex.

The correct diagnosis was not made until 18 months after his first complaints of shoulder pain. By this time he had developed definite weakness of both upper extremities, particularly the right arm, and diminished sensations in his right arm. The muscles of his right hand and arm were atrophied, especially those innervated by the ulnar nerve, and there was palpable fullness of his right supraclavicular fossa. Mediastinal and cervical node biopsies revealed poorly differentiated metastatic carcinoma. The patient was treated with radiotherapy followed by chemotherapy, but he deteriorated rapidly and died within three months.

Case 4—A 70-year-old man first complained to his physician of right shoulder pain which radiated to the right scapular region and right arm. X-rays of his shoulder and a bone scan were both unrevealing. He was referred to an orthopedic surgeon who treated him with intra-articular cortisone injection and physical therapy for the following eight to nine months.

As this therapy was unrewarding, he was then hospitalized for further investigations. Physical examination was essentially normal, except for crepitations in his right shoulder and ptosis with miosis in his right eye. He was a heavy smoker with non-productive cough—facts which were considered so unremarkable by the patient as to be ignored. Chest x-ray showed consolidation of the apex of the right upper lobe. Bronschoscopy and three separate sputum samples were negative; but scalene node biopsy, mediastinoscopy and needle biopsy of the right upper lobe indicated the presence of a squamous cell carcinoma of the lung.

Following cobalt therapy, a preoperative chest x-ray showed thickening at the right apical cap but no evidence of any involvement of the chest wall or the rest of the lung parenchyma. At operation, however, the tumor was found to be involving both the chest wall and the neurovascular bundle. The upper lobe was resected and a complete en-bloc resection of the chest wall was performed, including the first to the fourth right ribs. Some of the tumor surrounding the neurovascular bundle had to be left behind as it was infiltrating the neural sheath. Postoperatively, there were signs of progressive brachial plexus involvement and deterioration in his general condition. He died six months later.

Case 5—A 66-year-old man developed pain in his left shoulder and the medial side of his left arm. The pain was increased by looking to the right, a maneuver which presumably stretched the brachial plexus. He stopped smoking ten years previously due to severe peripheral vascular insufficiency. When he consulted his family physician about this pain, a chest x-ray was taken and revealed a tumor of the left apical cone. Although some scarring was seen in the right lower lung field with mild peribronchial thickening, there was no evidence of infiltration of the remaining lung parenchyma. The tumor was diagnosed as malignant only two months after he developed pain (apparently on clinical grounds alone), and he was given preoperative cobalt therapy.

At operation a tumor was found in the left upper lobe involving the chest wall and neuritic plexus. A radical resection of the left upper lobe with en bloc resection of the chest wall including the first to the fourth ribs and stripping of the brachial plexus was performed. Histology showed poorly differentiated squamous carcinoma which was necrotic due to the prior radiation therapy.

Although the other patients sought help early due to pain, this was the only patient in the group who was diagnosed promptly and rendered optimal treatment. He remained well and comfortable for 24 months following the operation. Recently, he developed signs of progressive brachial plexus involvement, but in view of his good general condition this is more likely to be due to post-radiation fibrosis than infiltration by tumor.

DISCUSSION

The brachial plexus is formed by the anterior branches of the lower cervical roots and the upper thoracic nerve root, which supply the whole of the upper limb and the shoulder girdle. Thus involvement of the plexus, especially the lower trunk, by tumor causes pain in the region of the shoulder and in particular the scapular, suprascapular, axillary and anterior thoracic areas. Pain also may originate in or radiate to the arm, especially the medial side in the distribution of the ulnar nerve.

Apical tumors are usually bronchogenic carcinomas; but similar effects occasionally are produced by osteogenic sarcomas, metastatic tumors, neurofibromas, mediastinal tumors, trauma, inflammation, and neoplasms of the cervical cord. Shoulder pain also may result from cardiac disease or diaphragmatic irritation, but these do not often cause confusion due to the presence of more specific symptoms and signs.

Pain is frequently the first and only symptom which causes the patient with a superior sulcus tumor to seek medical consultation. Initially, the quality of the pain, a nagging ache, mimics that produced by inocuous degenerative diseases such as arthritis. Later the pain develops a more dysesthetic quality, with a superimposed burning element indicative of nerve involvement. There often is an associated chronic "smoker's cough" which may be so familiar as to be ignored by both the patient and physician, but which merits closer scrutiny. It is not unusual for physical signs in the chest to be absent throughout the course of the disease.

Extension of the tumor leads to further compression or infiltration of the brachial plexus and sympathetic nerves, resulting in sensory and motor deficits, Horner's syndrome, atrophic changes and vasomotor disturbances at a late stage in the disease. If the diagnosis is not made before these advanced clinical signs supervene, much valuable time is wasted rendering successful therapy almost impossible. Obviously, evidence of superior vena cava obstruction and paraplegia are late and ominous findings indicating extensive spread of the tumor.

DIAGNOSIS AND TREATMENT

Radiological findings may be misleading in the early stages, especially if attention is directed exclusively to the shoulder or cervical spine, as evidence of calcification or athritic changes may encourage the diagnosis of a benign lesion. This occurred in 80 percent of our patients, who were all of an age when degenerative changes are common and all too easily accepted as the explanation for most complaints. It may be very difficult to demonstrate an early carcinoma of the thoracic inlet on routine chest x-ray, but careful comparisons of the pulmonary apices may reveal a small unilateral opacity. It is helpful to have posterior-anterior, anterior-posterior, lordotic and lateral films of the chest to obtain better views of the apices, especially in the early stages when changes may be minimal. However, in the majority of our patients the lack of early radiographic diagnosis was not due to deficiencies in the views obtained, but to failure to x-ray

"Pain is frequently the first and only symptom which causes the patient with a superior sulcus tumor to seek medical consultation."

". . . lack of early radiographic diagnosis was not due to deficiencies in the views obtained, but to failure to x-ray the chest because the possibility of apical lung tumor had not even been considered."

the chest because the possibility of apical lung tumor had not even been considered. Even if the lesion is visible on early radiograms, it may be mistakenly attributed to pleural thickening, as occurred in Case #3.[6] Additional procedures such as apical tomography and oblique views of the thoracocervical spine and ribs may suggest the correct diagnosis, as 29 percent of the patients are reported to have destructive lesions in the first three ribs or thoracic vertebrae.[7,8] On occasion, bone scans have been useful in establishing the diagnosis. They were corroborative in Case #1, and unrevealing in Case #4 in our series. Electromyography may help to localize the lesion to the brachial plexus.

Histological diagnosis is difficult to obtain prior to exploratory thoracotomy. Bronchoscopy can be singularly unhelpful as was demonstrated in our series. Scalene node biopsy and needle biopsy were more useful in establishing the diagnosis in our patients, but the latter has the potential problem of tissue contamination, which may complicate the problem of complete resection.

The Pancoast tumor previously had the unsavory reputation of being lethal at any stage, but in recent years there have been several reports indicating that early diagnosis combined with preoperative irradiation and complete en-bloc resection may result in long-term survival.[1-3] Early diagnosis and treatment, especially surgery of the brachial plexus and cervical sympathetic ganglia, also can contribute significantly to pain relief.[7] Although involvement of the chest wall, vertebrae and ribs is no longer considered an absolute indication of inoperability, early diagnosis is still essential before gross chest wall invasion makes complete resection impossible, or wide-spread dissemination throughout the body makes resection ineffective and inappropriate. Although many sophisticated diagnostic modalities are available, these are useless unless apical tumor is considered early and a search initiated. Thus, constant awareness of shoulder pain as an early symptom is possibly our most useful diagnostic tool.

It is pertinent that deaths from lung cancer in the United States in 1977 were 102,000, i.e., one in six of total deaths from cancer. As carcinoma of the apex of the lung represents about three percent of the total, this is no longer the rare condition it was 50 years ago. It is also likely patients referred to pain clinics represent only the tip of the iceberg. Therefore physicians and other health professionals, as well as the general public should be aware of the Pancoast tumor.

SUMMARY

Improved long-term survival now can result from early diagnosis combined with preoperative irradiation and radical surgery of apical lung tumors.[1-3] This makes early diagnosis imperative, but carcinoma of the apex of the lung is difficult to recognize before the full blown picture of Pancoast's syndrome appears. An early symptom is shoulder pain radiating to the arm, due to infiltration of the brachial plexus by the tumor. Abnormal physical findings are late indicating progression of the disease, usually to a stage where only palliative treatment is possible.

Our series of five patients illustrates delays in diagnosis resulting from persistence with unrewarding investigations and treatments. Constant awareness of these facts should lead the physician to consider apical tumor more often as a cause of pain in the shoulder and arm.

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CASE REPORTS

Echocardiographic Features of a Calcified Pericardial Tumor

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An echocardiogram showing posterior displacement of the anterior right ventricular wall with multiple irregular parallel echoes anterior to the right ventricular wall is reviewed. At surgery, a large calcified pericardial lipoma was removed. The utility of echocardiography as an adjunct diagnostic procedure in the evaluation of mediastinal masses is considered.

A 61-year-old man was hospitalized for evaluation of a mediastinal mass which was noted on routine chest x-ray. There was no previous history of heart disease, diabetes mellitus, or hypertension. Four months before this admission, the patient had undergone aspiration of a left renal cyst at another hospital. Physical examination revealed a slightly obese male with a blood pressure of 140/80 mm Hg and a regular pulse with a rate of 80/min. There was no neck vein distention. The chest was normal on percussion and auscultation. Examination of the heart showed normal first and second heart sounds without any accompanying murmurs or gallops. The electrocardiogram showed regular sinus rhythm with one episode of atrial fibrillation and poor R wave progression across the precordial leads. A posteroanterior x-ray showed normal lung fields with a large radiodense mass contiguous with the right heart border (Figure 1). In the lateral view, an area of calcification surrounded by a calcified shell was seen posterior to the sternum.

An echocardiogram was performed in the conventional manner with the transducer in the fourth left intercostal space, two cm from the left sternal border. The patient was examined in a partial left lateral decubitus position. A commercially available Unirad Series 100 ultrasonoscope with a 2.5 MHz, 0.5" transducer was used. A Honeywell Model #1858 Visicorder strip chart recorder was used to obtain the records.

The echocardiogram (Figures 2 and 3) revealed a large potential space measuring approximately 35 to 40 mm between the chest wall and the right ventricular wall. The motion pattern of the right ventricular wall was markedly exaggerated and distorted. Anterior to the right ventricular wall a series of irregular parallel echoes was present. These echoes corresponded to the calcification within the mass. Right heart catheterization and angiocardiography revealed normal hemodynamics, with compression and displacement of the right ventricle posteriorly and toward the left.

The chest was explored through a right posterolateral thoracotomy incision. A lobulated lipoma measuring approximately 15 x 10 x 3 cm and weighing 350 grams was found within the pericardial cavity. This tumor covered the anterior and right aspect of the heart and also part of the inferior vena cava and aorta. A calcified mass measuring approximately 7 x 5 x 2 cm was found within this tumor. In addition, there were several small areas of fat necrosis and calcification. The tumor was excised in its entirety (Figure 4). A repeat echocardiogram two and a half months post-

This study is from the Division of Cardiology, Maimonides Medical Center, Brooklyn. Dr. Cohen is affiliated with the Cardiology Section, Medical Service, VA Medical Center, East Orange. Drs. Gupta and Lichstein are now associated with the Division of Cardiology at Maimonides Medical Center, Brooklyn; Dr. Werner is at the Florida Medical Center, Fort Lauderdale; Dr. Chadda is at the Long Island Jewish Medical Center in New Hyde Park, N.Y. Correspondence may be addressed to Dr. Cohen at the VA Medical Center, East Orange, NJ 07019.

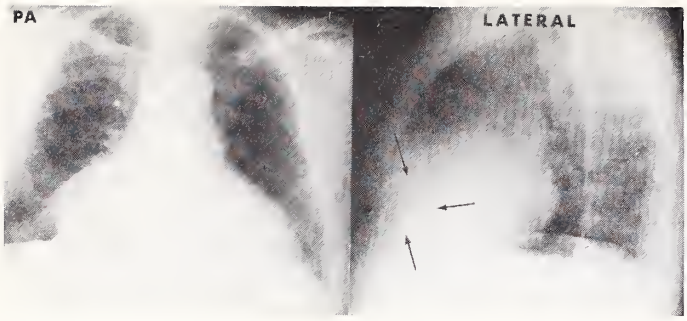

Figure 1—Posteroanterior (PA) and lateral views of the chest x-ray. The PA view shows a mass contiguous with the right heart border. In the lateral view, posterior to the sternum, there is a calcified mass (arrows).

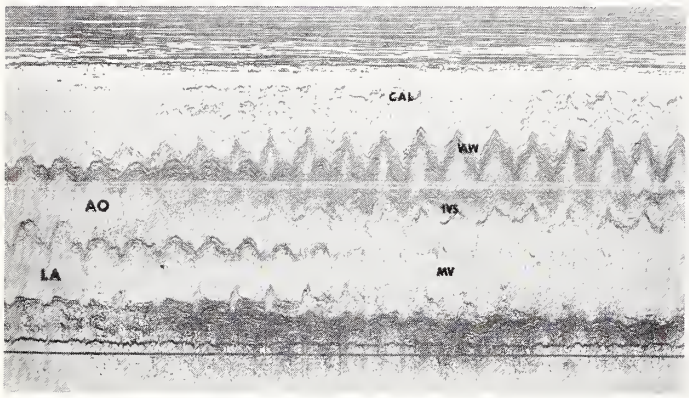

Figure 2—Echocardiographic scan from aortic to left ventricular position. Abnormal potential space anterior to the right ventricular wall (AW). Multiple irregular parallel echoes anterior to the right ventricular wall (CAL) represent motion of the calcified portion of the mass. Other abbreviations: AO-aorta, IVS-interventricular septum, LA-left atrium, MV-mitral valve.

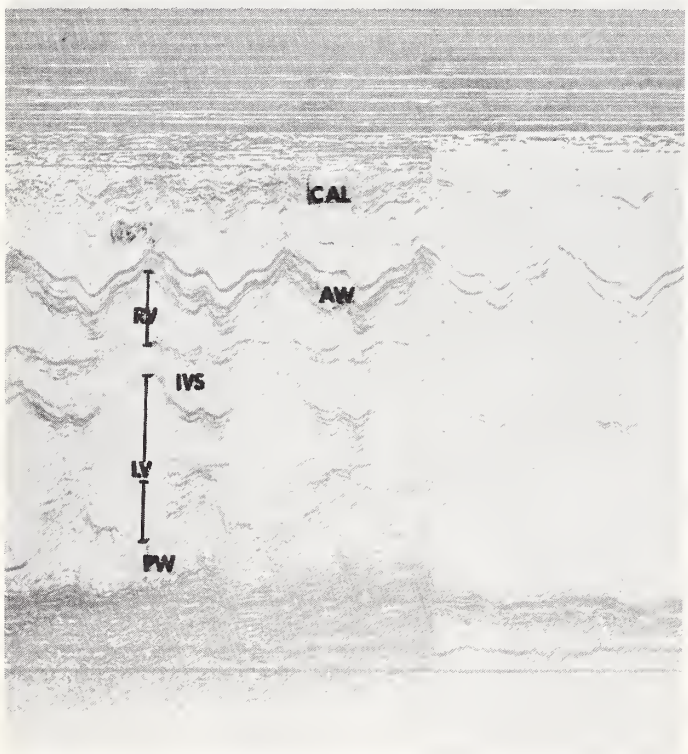

Figure 3—Echocardiogram at the level of left ventricle. The motion of the right ventricular wall (AW) is markedly exaggerated. The right ventricular cavity (RV) is compressed and the irregular parallel echoes (CAL) are seen anterior to the right ventricular wall. The interventricular septum and posterior wall (PW) show normal motion.

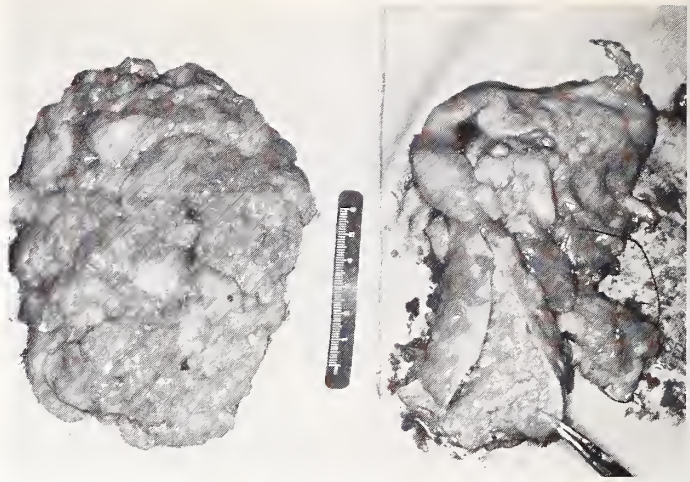

Figure 4—Surgical specimen of excised pericardial lipoma.

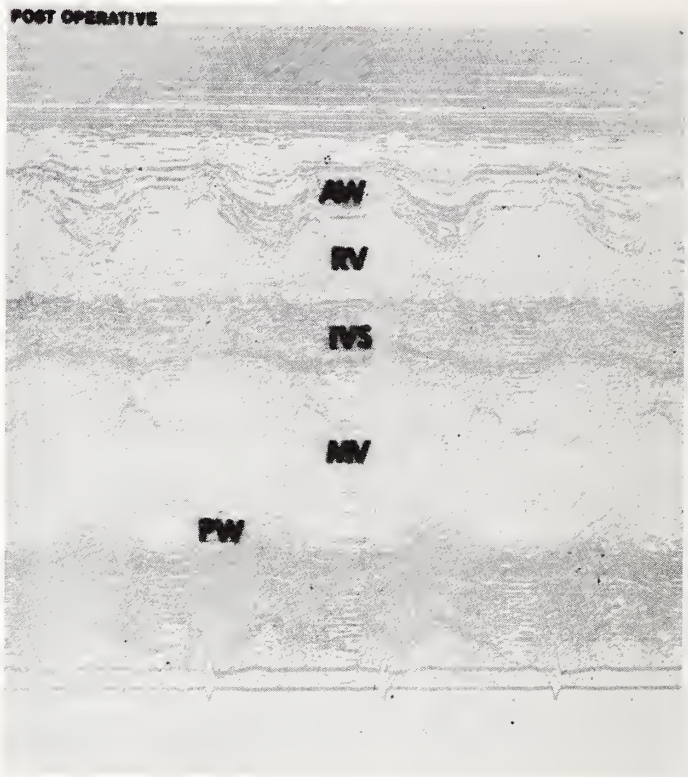

Figure 5—Postoperative echocardiogram. There is an anterior seven mm echofree space. The interventricular septum shows diminished motion.

operatively (Figure 5) demonstrated an anterior echofree space of about seven mm with normal motion pattern of the right ventricular wall. However, the interventricular septal motion was diminished compared to the preoperative echocardiogram.

DISCUSSION

Under normal circumstances, the right ventricular wall is close to the anterior chest wall, hence no potential echofree space exists between the two structures. Occasionally, an anterior echofree space of less than five mm may occur as a result of retrosternal fat. The most common cause of an abnormal increase in this anterior echofree space is pericardial effusion, which invariably is accompanied by a concomitant posterior echofree space.[1,2] Conditions producing isolated anterior echofree space include loculated anterior pericardial effusion, anterior pericardial cysts, anterior mediastinal tumors, excessive retrosternal adipose or fibrous

"The most common cause of an abnormal increase in this anterior echofree space is pericardial effusion."

"Masses lying toward the right side and superiorly usually cannot be visualized on the echocardiogram."

tissue, marked obesity and rarely, diaphragmatic hernias.[2-5] In many of these conditions, there is marked distortion and exaggeration of the motion pattern of the right ventricular wall, which results from loss of support of the anterior chest wall. Exceptions to the rule may, however, occur.[5]

Occasional case reports concerning the diagnostic value of echocardiography in patients with mediastinal tumors have appeared.[3,4] In many patients with mediastinal tumors, the usefulness of echocardiography is limited because of the anatomic location of the mass. To be visualized on the echocardiogram, the mass should be in the path of the ultrasonic beam, i.e., it should lie anterior to the heart.Masses lying toward the right side and superiorly usually cannot be visualized on the echocardiogram.

Some investigators have used serial echocardiograms to follow the size of the mediastinal tumors in assessing the role of chemotherapy in patients with inoperable malignant masses[3]. In our patient, the presence of irregular parallel echoes anterior to the right ventricular wall made us lean more toward the diagnostic possibility of a mass rather than a pericardial cyst or loculated effusion. The persistence of approximately seven mm anterior echofree space following surgery could have resulted from postoperative fibrous tissue. Also, the diminished septal motion seen on the postoperative echocardiogram is consistent with the finding seen in patients after pericardectomy [6]. Although we have no experience, we believe that mediastinal teratomas with teeth and bones will have a distinct echocardiographic appearance.

CONCLUSION

The echocardiogram can be of significant help in the diagnostic evaluation of patients with mediastinal masses, especially if the mass is located in the anterior mediastinum.

SUMMARY

The echocardiogram of a patient with a calcified anterior pericardial lipoma showed posterior displacement of the right ventricular wall with an increase in the potential space between the chest wall and the right ventricle. Multiple irregular parallel echoes anterior to the right ventricular wall corresponded to the calcification within the mass. A right ventricular angiocardiogram showed compression and posterolateral displacement of the right ventricle by the calcified mass. Postoperavely, the echocardiogram returned to near normal.

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Purulent Meningococcal Arthritis in an Adult *

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A case of purulent meningococcal arthritis is reported in a patient who had no clinical evidence of meningitis and in whom bacteremia was not documented. The incidence, clinical manifestations, and possible pathogenetic mechanisms of meningococcal arthritis are discussed.

Arthritis complicating meningococcal meningitis and meningococcemia is well recognized, but the occurrence of acute meningococcal arthritis in the absence of proven infection elsewhere in the body is rare[1]. Indeed, recent reviews of infectious arthritis either fail to mention this entity at all or make only passing reference to it[2,3]. We recently had occasion to care for a patient with meningococcal arthritis who had no other evidence of meningococcal disease, prompting this case report and literature review.

CASE HISTORY

A 54-year-old previously healthy female was admitted to St. Peter's Medical Center, New Brunswick, New Jersey with a one-day history of fever and shaking chills. Review of systems was unremarkable except for a vague history of "osteoarthritis of the hands."

On admission the patient's temperature was 39.5°C with a pulse of 110 per minute. Other vital signs were normal and the physical examination was within normal limits. Complete blood count showed a leukocyte count of 8,700 cells/mm^3 with 77 percent polymorphonuclear leukocytes and 14 percent band forms. Urinalysis, blood chemistries, including uric acid, and chest x-ray were all within normal limits.

On the second hospital day the patient developed arthralgia of the right knee, and a generalized nonpruritic macular rash. On the third hospital day the right knee was no longer painful, and the rash disappeared. However, the left knee became acutely tender, swollen, erythematous, and warm to the touch. The leukocyte count rose to 13,800 cells/mm^3 and the left shift persisted. Erythrocyte sedimentation rate was 107 mm per hour (Westergren). A urine culture and three blood cultures were obtained.

Arthrocentesis of the left knee joint yielded 120 ml of opalescent fluid of low viscosity. The fluid contained 40,000 red blood cells/mm^3 and 35,000 white blood cells/mm^3 of which 90 percent were polymorphonuclear leukocytes. Synovial fluid glucose was 44 mg/dl with a simultaneous blood glucose of 160 mg/dl (5 percent dextrose and water was being infused intravenously). Gram stain of the joint fluid revealed many polymorphonuclear leukocytes but no organisms. The following day the fluid grew Neisseria meningitides, subsequently classified as Group B by the laboratory of the New Jersey State Department of Health. All other cultures remained sterile.

On the fifth hospital day the patient developed herpes labialis which spread to involve the left side of her face and neck. She also developed pain, erythema, and tenderness of the left first metatarsophalangeal joint. However, no

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evidence of joint effusion was present, and arthrocentesis of this joint was not attempted. Aqueous penicillin G in a dose of 2 x 10^6 U intravenously every three hours was begun and symptoms in both the knee and metatarsophalangeal joints improved within 48 hours. However, temperature to 38°C daily persisted for nine days. Penicillin was discontinued after ten days. Stiffness of the knee joint and effusion persisted for two weeks after completion of antibiotics. Repeat arthrocentesis yielded a small amount of bloody synovial fluid which was sterile. The quantity of fluid was insufficient for a cell count. Indomethacin was prescribed with dramatic improvement. Upon discharge from the hospital the patient was able to ambulate using a walker; followup evaluation two months later revealed complete recovery with no residual functional impairment.

DISCUSSION

Arthritis occurs in two to ten percent of patients with other manifestations of meningococcal disease[4,7]. Most cases have been described during epidemics[4,5,8] but arthritis associated with sporadic episodes of meningococcal infection has been reported [1,9]. To our knowledge, this is the second reported case of arthritis due to Neisseria meningitides type B, despite the fact that this serotype is presently the most common cause of sporadic meningococcal infection in the United States [10]. In the previously reported case the organism was isolated from both blood and throat but not from synovial fluid[11].

There are probably two clinical syndromes of meningococcal arthritis[5,7]. One (type A) is an acute polyarthritis without effusion which appears early during the course of infection and is accompanied by a generalized rash.[5] This arthritis subsides as the rash disappears. The second (type B) syndrome occurs later in the course of infection, is usually monoarticular, is associated with significant joint effusion, and lasts one to four weeks with gradual and complete recovery.[5,7] The joint fluid is described as purulent, and positive cultures are present in approximately one-third of specimens. It has been suggested that it is not always possible to distinguish clearly between these two clinical syndromes;[12,13] it seems possible that the patient presented herein had both forms of meningococcal arthritis, type A occurring transiently on the second hospital day and type B developing on the third hospital day.

The pathogenesis of meningococcal arthritis is unclear, and the findings in our patient emphasize the reasons for confusion. In 1934 Keefer *et al.* presented data suggesting that meningococcal arthritis was a manifestation of disseminated infection.[14] More recent observations have caused this view to be questioned. First, the causative organism is uncommonly isolated from the presumed infected site.[1,4,6] Second, the type B syndrome usually occurs as the acute meningococcal infection is subsiding, often three to six days after successful antibiotic therapy has been instituted.[1,7] Third, antibiotics seem neither to prevent the development of arthritis nor greatly modify the course once it has occurred.[7] Indeed, evidence has been presented supporting an immunologic basis for the occurrence of meningococcal arthritis.[7,16] Greenwood *et al.* recently have studied synovial fluid from patients who developed arthritis after meningococcal meningitis.[16] Synovial fluid leukocytes from five patients were found to contain meningococcal antigen and immunoglobulin that stained strongly for the third and fourth components of complement. Moreover, a transient decrease in serum C3 levels occurred in the patients studied by this group. Thus evidence for pathogenetic mechanism involving immune mediated phenomena is suggested by these investigators.

The findings in the patient we report could be used to support both an infectious and an immunologic basis for meningococcal arthritis. The presence of the organism in the joint fluid presumably occurred on the basis of a bacteremia which was not detected and antibiotic therapy was temporally associated with at least partial improvement. Later in the course there was dramatic improvement following the institution of an anti-inflammatory drug often used to treat patients with immunologically-mediated arthritis.

Finally, this case serves to emphasize further the occasional indistinguishability of meningococcal and gonococcal disease, a phenomenon previously described by others.[9,11,17]

SUMMARY

This patient with acute meningococcal arthritis demonstrated a relatively unusual presentation of this syndrome. More often meningococcal arthritis occurs during antibiotic therapy as the patient is recovering from either meningococcal meningitis or septicemia. Most evidence suggests an immune mediated pathogenesis in this entity.

Disease syndromes caused by the meningococcus and gonococcus may be difficult to separate on clinical grounds alone, and cultures are necessary to identify the etiologic agent with certainty.

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SPECIAL ARTICLE

Of Women and Men (Doctors): Confessions of a Female Chauvinist

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Men and women physicians may be indistinguishable as physicians but they differ greatly as people. Women live; men work. Women are strategists; men are tactitians. With the superiority of women clearly established, I suggest that it may be possible for some men to match the achievements of women.

Why can't men (doctors) be like women (doctors)? Women are so . . . superior! Ericson might have been talking about us when he described, "(a species) . . . planned by an all-wise deity, created in a special cosmic event and appointed by history to guard the only genuine version of humanity."[1]

Probably all women are superior to all men, but since this is a scientific paper I won't generalize; my researches have been limited to men and women doctors. Now please don't misunderstand me. Men often are very good *doctors*. It's that women not only are good doctors, but also are very good people.

This superiority manifests itself in two ways. If you ask patients who are nicer, women or men doctors, they will answer with one voice "women!" In addition to practicing good medicine, patients say, women physicians are more patient, respectful, and warm. Patients are often afraid to badger male doctors, but they rarely hesitate to phone a woman physician who immediately responds sympathetically. That is why women physicians have so many more challenging, i.e., chronic, difficult and intractable patients.

Women physicians are also outstanding in community life. Everyone knows that male physicians only *talk* about medicine (provided it's not about your symptoms), so one doesn't invite too many male physicians to one party. Also, male physicians can only *do* medicine, so you don't ask them to fix the plumbing or take a hand with the eggbeater. Women physicians are very handy at home, and they are always right up there on current events and issues. They are a delight at parties because all women physicians also do something else. They are either the president of the PTA, or they hold the neighborhood apple pie baking championship, or they contribute to *Ms. Magazine* Furthermore, women physicians will always let you take them off to the side for a brisk chat about your hypertension or your hot flashes.

I don't know why all this should be true for women physicians. It may be as Karen Horney said: women are endowed by nature with superior anatomy.[2] Because of their anatomical advantage, women can simply *be;* men have to *do.* If you don't follow the plot on this one, think of the sex act. To succeed at sex a woman simply has to be; the man has to do. To be able to succeed without effort endows women with a natural superiority.

The other reason for the superiority of women is that women can be mothers. Biologically endowed with both the capacity and the responsibility for perpetuating the human race, women have assumed a social role consistent with the task. *Noblesse oblige!*

Men also play a part in propagation, of course, but theirs, if they choose is a hit-and-run function. Women hang in for the finish.

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In medical school I had a best friend, Joe. We each had a spouse, a couple of kids, a house and a lawn. At the end of the day, I always rushed home. Shedding laboratory coat, clutching and collecting notes, books, slides and microscope, I raced for the parking lot, determined to get out before the mob. On my way I invariably passed Joe, in a telephone booth, telling his wife that he would not be home, there was too much work to do and that he was sorry. We were both happily married and both marriages endure to this day.

Joe was neither a better student nor dumber than I. He did not need to work harder. I once asked him why he spent so much time in school. He couldn't understand the question. "If I went home I'd get all involved with Joyce and the kids. I have to study in peace." I felt sorry for him!

Joe and I are prototypes. I say *are* rather than *were* because he is now as he was then and so am I. And we fit right in with most common female and male physician types.

Ten years ago I asked a random sample of 100 married women physicians what their lives were like. I also asked them to describe their husbands' lives. Over half of these women was married to physicians so I was able to compare men and women physicians living in the same family.[3,4]

Both women and their spouses were busy 80 hours a week, but while the husbands were almost exclusively preoccupied with work, the wives did much besides. Some husbands helped, but the women were always in charge.

To broaden my research I've been snooping on friends and shamelessly buttonholing acquaintances and strangers at meetings and conferences, asking nosey questions about their life style. The answers are remarkably uniform: women physicians live complex lives; the lives of men physicians are much simpler.

Since I graduated from medical school, I have been teaching students and housestaff. Contemporary rhetoric notwithstanding, the young women and men in training today are headed straight for where their predecessors are.

A former woman student, now colleague, was paged to the telelphone at an out-of-town convention. (She was single when she was a student, hung around and drank beer with the guys. I wondered what would become of her.) Her husband was looking for her. She had left him in charge of their new joint practice and their household for a week. The practice was fine, and he knew that it was Tuesday. He also knew that he had some kids. But where the devil were they?

Remember what they used to say about former president Gerald Ford? He couldn't walk and chew gum at the same time said the wits and the wags. But the joke's on them! Very few men can walk and chew gum at the same time. Very, very few men (doctors) can. All women can. All women (doctors) can. Joe couldn't. I could. My old student can, her husband can't.

Men are very good at tactics. They wage wars, invent atomic bombs, write poems, and become cardiologists. Women do all that, but women also keep the whole scheme of things in their heads.

Women can and do just about everything that men can do. The converse isn't always true. In the days I employed nurses for my babies, once only did a man apply for the job. He was a transvestite, working to earn money for a sex change operation!(sic) Women work on the docks, play the violin and take out gallbladders. I know no woman physician who isn't at any one time simultaneously juggling her patients, the dinner menu, the children's Hebrew (Communion) class, an exercise class and a paper due at next week's conference. In between she squeezes in her parents, the inflation, and one or two hobbies.

These attributes of women transcend ethnic, racial and cultural differences. Rich women, poor women, yellow, white, and black women doctors are indistinguishable from one another while all are totally different from men.

Notice that the subject of childbearing and childrearing recurs in this article. Contrary to prevalent myths, women are not unhappy with mothering and have no wish to abrogate it. Some women want to jettison their men, but that's different from jettisoning children. The notion that women envy men, want to be like men and want to repudiate their special feminine talents including childbearing and childrearing is a male invention foisted off on women by men jealous of the women's extraordinary powers. (see Horney.) Even lesbian women are contriving to bear children. Recently a women got herself impregnated by a husband whom she was about to leave. She did not want him, but she did want a child, and having the husband father her child seemed . . . neater, than drafting a stranger for the job.

Reports are coming in from areas as remote as Israel and Russia, that emancipated or not, women remain women enmeshed in multiphasic lifestyles, while the men's lifestyles remain basically one track.[4]

Some women are overwhelmed by the superwoman image and in this context, some may express wishes to be more like men who get by on so much less. These women fail to grasp Darwinism. Women survive—thrive—in their complex lives because women are so very fit. If men do less it is because they can't do more!

Women (doctors) are superior. They can't help it. Is there any hope for the men?

The principle of affirmative action is relevant here. Although men may lack women's enviable talents and do not have the qualifications for the many tasks women perform, men can be actively drafted and patiently encouraged as they learn. With good will, determination and practice, it is possible to overcome biological barriers and some day, a few very superior men might even almost match women!

My conclusion will infuriate some on both sides of the great sex divide. Men can make great strides. A few will reach women. But the hand that rocks the cradle rules the world and will continue to do both even if with increasing frequency it also picks up the scalpel.

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STATE OF THE ART

Synovianalysis

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Synovianalysis is an important procedure in the differential diagnosis of rheumatic diseases. Arthrocentesis to obtain synovial fluid permits simple and complicated techniques of analysis to identify the type of fluid. One then may classify such fluid as non-inflammatory, inflammatory, septic or hemorrhagic. Representative cases demonstrate how synovianalysis aided in proper diagnosis and therapy.

Synovianalysis is a term coined by Hollander *et al.* to designate certain gross and microscopic procedures applied to joint fluid which provide valuable information in the differential diagnosis of the various arthritides (Table 1).[1] Just as the physician examines the blood in patients presenting with coagulation disorders, or the urine in patients with renal disease, so examination of the synovial fluid should be routine in patients with arthritic complaints.

Arthrocentesis of a joint that contains a large amount of fluid to obtain synovial fluid is usually easy. This procedure may be likened to puncturing a balloon—easier to accomplish if it is distended rather than collapsed. A working knowledge of the anatomy of the area is essential to avoid traumatizing major vessels or nerves. Certain generalizations can be made:

1. It is easy to avoid infection by using disposable syringes and needles. The skin may be prepared with just swabbing with alcohol. Although many older orthopedic texts recommend draping the area and using surgical gloves and masks, I have found these completely unnecessary. I have performed several thousand arthrocenteses, and to my knowledge never have introduced an infection.

2. Fluid is obtained most easily from the knee joint, followed by the ankle, shoulder, elbow and various bursae. It is often difficult to aspirate the small joints of the fingers and the hips to obtain fluid.

3. Local anesthesia in the form of ethyl chloride spray is often all that is needed for patient comfort.

4. About the only contraindication to this procedure is infection involving the overlying skin or soft tissues. A needle passing through an infected area can introduce infection into a joint.

On removal of the fluid, gross examinaion in the office or at the bedside is in order. Certainly, Group I or Group IV (Table 1) fluid may be determined by gross inspection, leaving Group II or Group III to be differentiated in the laboratory. Viscosity can be determined by pushing some fluid out of the syringe. Normal fluid and noninflammatory fluid will string out like molasses, while inflammatory or purulent fluid will drip like water. This occurs because polymerization of the sticky substance of joint fluid is impaired by the lysozymal enzymes produced by the inflammatory process. Clarity easily can be determined by attempting to read print through the fluid. Normal or noninflammatory fluids are transparent, while inflammatory or purulent fluids are opaque. The opacity is roughly proportional to the leukocyte count (Table 2).

Laboratory evaluation is divided into the routine and the more sophisticated evaluations (Table 3):

1. **Routine testing**—A total white blood count and differential easily may be performed in a physician's office or laboratory. The procedure is similar to the peripheral white

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Table 1*

I	II	III	IV
Noninflammatory	Inflammatory	Purulent	Hemorrhagic
Normal	Rheumatoid arthritis	Bacterial infections	Trauma (especially with fracture)
Trauma	Crystal-induced synovitis:		Blood dyscrasias
Osteoarthritis	Gout		Pigmented villo-nodular synovitis
Amyloidosis	Pseudogout		Excessive anti-coagulation therapy
Systemic lupus erythematosus	Spondyloarthropathy		
Vasculitis	Reiter's Syndrome		
	Psoriatic arthritis		
	Inflammatory bowel disease		
	Rheumatic fever		
	Rubella arthritis		

*Not all inclusive

Table 2
Routine Studies

Criteria	Normal	Noninflammatory	Inflammatory	Purulent
1. Volume (knee)	< 3.5	> 3.5	> 3.5	> 3.5
2. Clarity	Transparent	Transparent	Opaque	Very opaque
3. Viscosity	High	High	Low	Low
4. Leukocytes (mm3)	< 200	200-2000	2000-100,000	20,000-200,000
5. Polymorphs %	< 25%	< 25%	> 50%	> 75%
6. Culture	Negative	Negative	Negative	Usually positive

Table 3
Routine Procedures

1. Gross examination
   a. color
   b. clarity
   c. viscosity
   d. volume
2. White blood count
3. Differential Wright's stain

Special Studies

1. Polarized light microscopy
2. Synovial fluid rheumatoid factor
3. Ratio of:
   Synovial fluid total hemolytic C'
   serum total hemolytic C'
4. Gram stain, culture, sensitivities

blood count, the only difference being the use of normal saline as a diluent. Wright's-stained smears are used for the differential. These studies help to differentiate the majority of joint fluids (Table 2). If infection is suspected, gram staining and culture should be performed.

2. **Special studies**—An essential although complicated procedure that must be performed in virtually all cases is an examination of a wet preparation under compensated polarized light microscopy. This differentiates the two main causes of crystalline arthropathy: gout[2] and pseudogout[3]. Although a polarizing light microscope with a first-order red compensator may not be available, a simplified "home-made" system may be applied to an ordinary microscope with the use of Scotch tape and Polaroid sunglass[4].

Another relatively complicated procedure is the evaluation of complement in both serum and synovial fluid, since rheumatoid effusions typically have a low ratio of complement in the synovial fluid as compared to serum.[5] Although not a routine procedure, the results often may be the only laboratory confirmation to correlate with a clinical diagnosis of rheumatoid arthritis. In Reiter's syndrome the ratio is often elevated.

If the fluid is hemorrhagic it is important to rule out a traumatic tap. A hematocrit of greater than 10 percent usually means hemorrhage into the joint. (Figures 1 and 2)

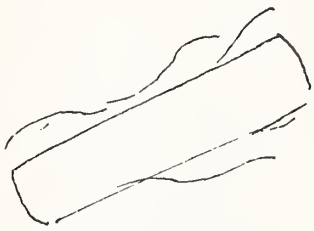

Figure 1—Rhomboid-shaped calcium pyrophosphate crystal.

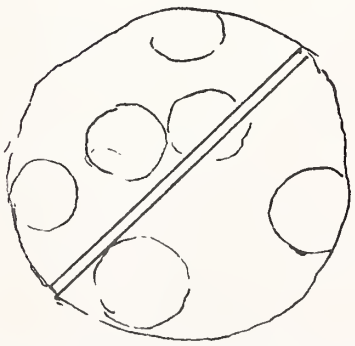

Figure 2—Needle-shaped intracellular urate crystal.

ILLUSTRATIVE CASES

Case #1—A 56-year-old school teacher complained of recurrent knee effusions over the past year which had been treated by aspiration and instillation of steroids by another physician. She had a host of minor complaints, including lassitude, diffuse pains, change in personality and constipation. Aspiration of her knee revealed 30 ml. slightly opaque fluid with low viscosity. Leukocyte count was 11,500 with 76% polys and 24% lymphocytes. Wet smear under polarized

light revealed weakly positive birefringent crystals consistent with calcium pyrophosphate deposition. Radiographs of the knees were essentially negative. Because of the known association of various metabolic diseases with this type of arthritis, additional studies were ordered. A serum calcium was found to be 13.4 mg/dl. The patient was admitted to the hospital. Because of increasing lethargy before further evaluation could be performed, surgical exploration was undertaken; a large parathyroid adenoma was found and removed. Six years after surgery the patient is well and symptom free.

Case #2—A 56-year-old machinist was seen because of poor response to treatment for his "rheumatoid arthritis." He had polyarticular pain and swelling associated with morning stiffness and progressive disability. Aspiration of one of his "rheumatoid nodules" produced a drop of chalky material containing massive amounts of strongly negative birefringent crystals pathognomic of gout. Treatment was immediately directed toward this diagnosis, and two years later the patient is almost symptom free. His tophi have decreased considerably in size.

Case #3—A 60-year-old male recovering from an acute myocardial infarction was seen in consultation because of a swollen knee. His physician had started phenylbutazone two days prior to this for a tentative diagnosis of gout. The patient was also receiving Coumadin® daily. On aspiration a Group IV hemorrhagic fluid was removed. A stat prothrombin time was nine percent. Both drugs were discontinued and the patient had an uneventful recovery.

CONCLUSIONS

As depicted in the case reports, synovianalysis is often the key to developing a proper diagnosis of a rheumatic disease so that a rational therapeutic program can be instituted.

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Gated Radionuclide Angiocardiography in the Differential Diagnosis of Right Ventricular Infarction*

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The new techniques of gated radionuclide angiocardiography (GRNA) are gaining widespread clinical popularity in pace with their newfound applications. Although technically complex, requiring dedicated minicomputers, GRNA offers new insight into diagnoses, and provides opportunities to perform serial studies to assess changing ventricular function.

Scanning is performed after labeling the patient's intravascular space with 10 to 25 millicuries of Tc-99m. The preferred method at present is to label the patient's own red blood cells *in vivo* with a technetium-stannous pyrophosphate complex. This method allows for excellent quality scans over eight to twelve hours. A single crystal gamma camera is used to obtain scans in the anterior (or RAO) and LAO projections. The gamma emissions from the technetium-labeled red blood cells then are used to construct a nuclear cardiogram by employing the minicomputer. Three opposing requirements are at work: (1) acquiring a sufficient number of counts to construct a statistically reliable image; (2) minimizing radiation exposure to patient and staff, and (3) gamma camera and computer limits of counting rates. The concept of the gated images blends these three forces nicely.

Briefly, gating is achieved by programming the computer to detect the R waves of the patient's electrocardiogram and divide the R-R interval into a user-selected number of equal frames. Counts from each predetermined time interval after the R wave of successive beats are deposited into each gate until the desired count density is reached (requiring 100 to 400 beats). A flicker-free cine of these gates then can be constructed to produce a cineangiogram of cardiac motion over the R-R interval. Beats with R-R intervals outside the preselected window are excluded by an arrhythmia filter. Patients with atrial fibrillation or other arrhythmias with widely varying R-R intervals cannot be studied with this technique.

Since count rate is proportional to blood volume, ejection fractions can be calculated from within an operator-selected region of interest. The results from our laboratory demonstrate an excellent correlation (r=.92) between left ventricular ejection fraction by GRNA and contrast ventriculography. We also have shown a GRNA sensitivity of greater than 90 percent in detecting qualitative abnormalities in left ventricular function seen at cardiac catheterization, confirming the previously reported accuracy of the technique.

The techniques of GRNA have been used to assess left ventricular function at rest and during exercise in coronary and valvular heart disease. Drug effect on ventricular function also has been studied. Insights into right ventricular pathophysiology using this method now are being described. The GRNA diagnosis of right ventricular infarction in association with inferior wall myocardial infarction recently has been reported. The clinical diagnosis of right ventricular infarction is often difficult, yet therapeutic approaches to low cardiac output in the setting of acute inferior wall infarction diverge widely depending on the extent of right and/or left ventricular dysfunction. Fluid infusion is the cornerstone of therapy for right ventricular infarction, while arterial afterload reduction and diastolic augmentation with intra-aortic balloon pumping, or powerful inotropes may be employed if severe left ventricular dysfunction is present.

The prevalence of right ventricular infarction in inferior wall MI has been reported to vary widely, depending on methods of patient selection and diagnostic techniques employed. Right ventricular infarction in the setting of acute inferior wall MI has been seen in 2.6 percent of patients using clinical criteria, 24 percent of patients in an autopsy series, and as high as 40 percent of patients using GRNA in the acute phase of infarction. This wide discrepancy in prevalence reflects on the sensitivity of the above-described techniques in establishing the diagnosis.

Clinically, the diagnosis of acute right ventricular infarction is suggested by elevated jugular venous pressure, absence of pulmonary edema, and signs of peripheral hypoperfusion in the setting of acute inferior wall MI. Swan-Ganz catheterization will reveal normal to mildly elevated pulmonary capillary wedge pressures (depending on the extent of left-sided involvement) and a low cardiac output if right ventricular dysfunction is severe.

Cardiac tamponade can be mimicked as patients with right ventricular infarction often present with paradoxical pulse,

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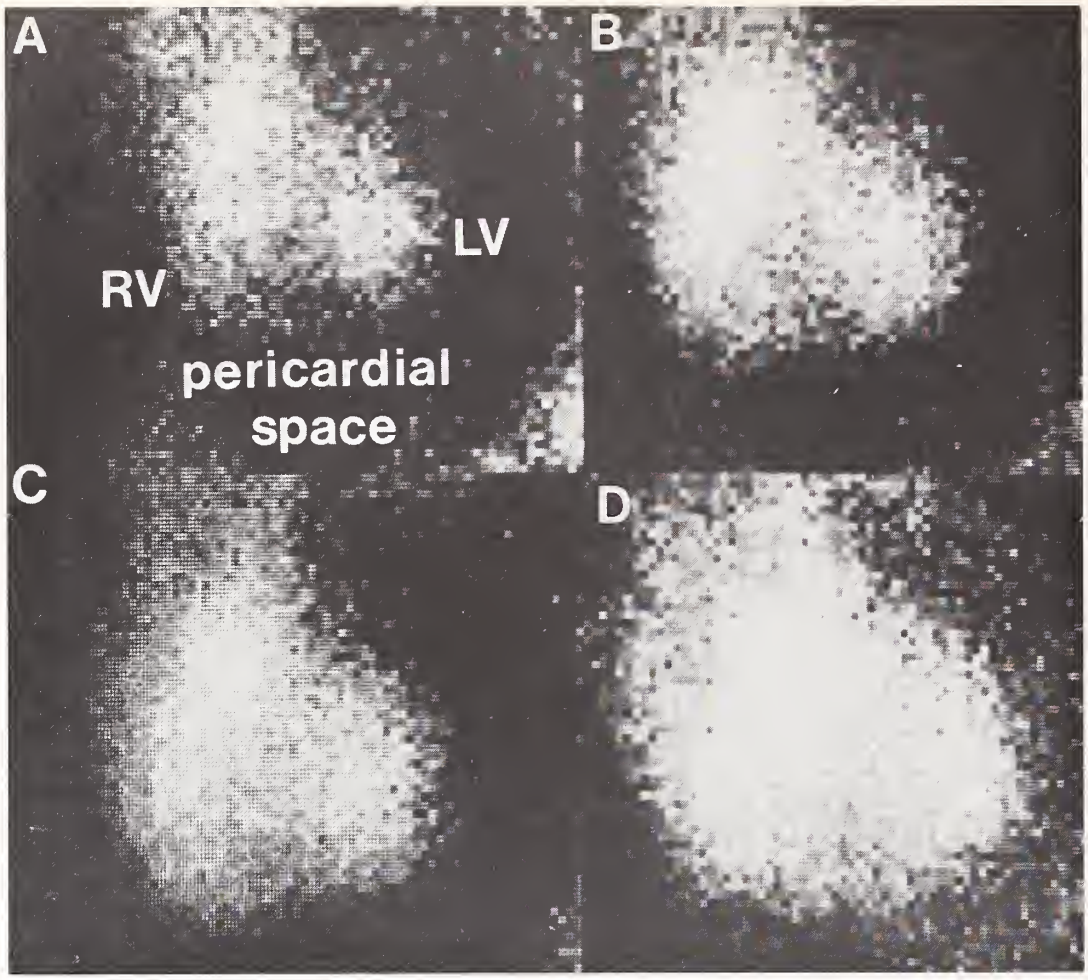

Figure 1 (A-D)—Sequential gated radionuclide angio-cardiograms in the left anterior oblique projection in a patient with a massive pericardial effusion and cardiac tamponade. A—Baseline study, note the small, nearly equal area of both ventricles with a large clear space around the heart representing radioisotope-free pericardial fluid pushing the lungs aside. B-D—as fluid is drained from the pericardial space intraventricular area increases (B,C,D) and the lung free clear space disappears (D).

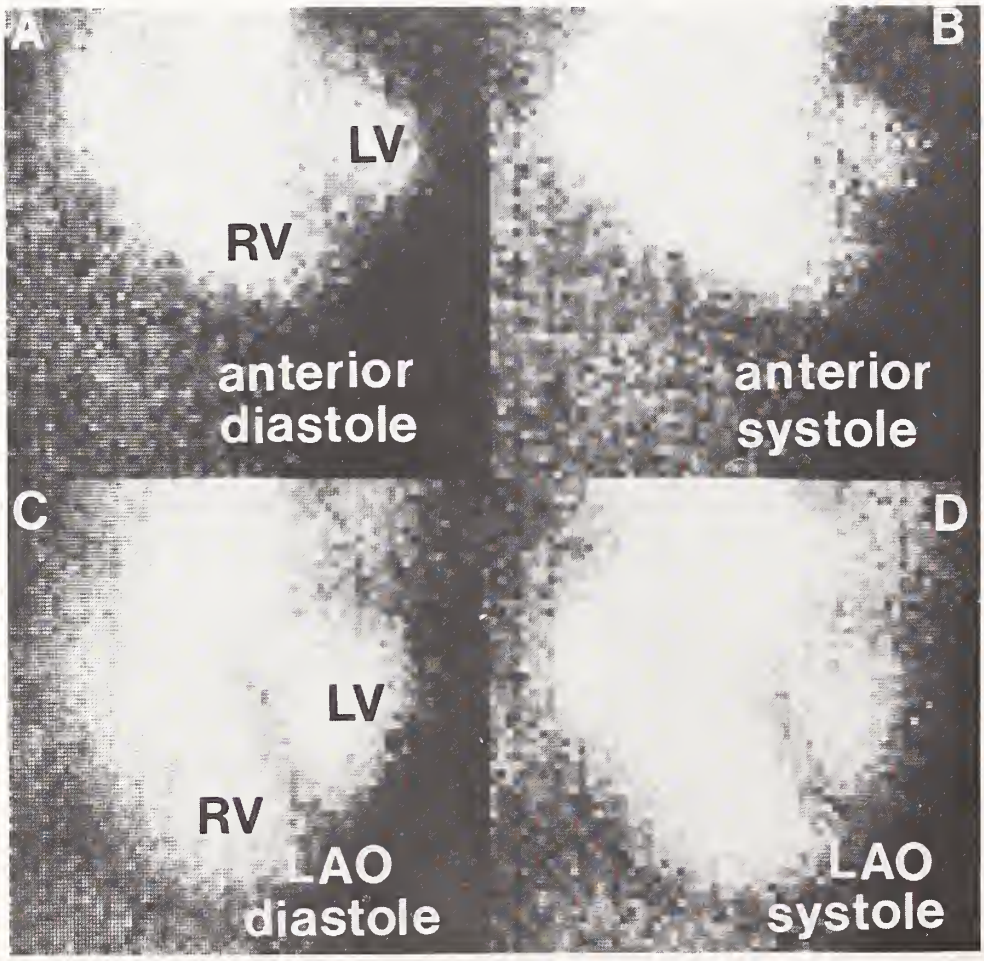

Figure 2—A and B—Anterior projection: end diastolic and end systolic frames. C and D—Left anterior oblique projection: end diastolic and systolic frames. GRNA study of a patient with a right ventricular infarction in the setting of acute inferior wall myocardial infarction. The right ventricle is moderately dilated and virtually akinetic. There is a mildly abnormal left ventricular contraction pattern with hypokinesis seen in the inferior wall in the anterior projection. Left ventricular ejection fraction 55 percent, right ventricular ejection fraction 20 percent.

elevation of jugular venous pressure and equalization of diastolic pressures in all four chambers as manifestations of severe right ventricular failure. In other patients, a dip and plateau pressure trace in the right ventricle closely mimicks that seen in patients with constrictive pericarditis. Echocardiography can rule out tamponade by excluding pericardial effusion, but in those patients with a right ventricular infarction and a picture suggestive of constrictive pericarditis or coincidental pericardial effusion, echocardiography offers little in the differential diagnosis. The findings of right ventricular infarction by GRNA are quite characteristic although their sensitivity has not been established in the setting of acute inferior wall MI. Typically, GRNA demonstrates a dilated poorly contractile right ventricle with a normal or mildly dilated left ventricle in the absence of preexistent heart disease. If extensive left ventricular disease were present along with right ventricular infarction, the GRNA picture would be one of biventricular failure as seen in congestive cardiomyopathy. This picture contrasts markedly with that seen in cardiac tamponade or constrictive pericarditis where both ventricles are small and hypercontractile (Figures 1 and 2).

Since the prognosis and therapeutic approach to cardiogenic shock secondary to right ventricular dysfunction is markedly different from that due to left ventricular failure, the diagnosis of right ventricular infarction should be aggessively sought and confirmed. It would appear that GRNA will be a useful tool in this differential diagnosis.

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THERAPEUTIC DRUG INFORMATION

This information is compiled by the Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Arnold and Marie Schwartz College of Pharmacy and Health Sciences, Long Island University.*

1. Do you have any information on the intranasal use of synthetic luteinizing hormone-releasing hormone (LH-RH) as a contraceptive.

Paradoxically, chronic administration of LH-RH inhibits ovulation.[1] Synthetic analogues of LH-RH active by the intranasal route may represent a new approach to fertility control.

Kledzik *et al.*[2] demonstrated in rats, that a synthetic analogue of LH-RH possessed definite antifertility activity. Their data suggested that the antifertility effects are mediated by a decreased luteal phase and alteration in the regulation of ovarian gonadotropin receptors.

Koyama and associates[3] showed, in six women with normal menstrual cycles, that once-daily subcutaneous administration of exogenous pharmacological doses of LH-RH for five days during the post-ovulatory period induced functional luteolysis. Similarly, Lemay *et al.*[4] demonstrated in ten volunteer women a luteolytic effect resulting from subcutaneous administration of LH-RH.

Lemay and associates[5] in a study involving six women indicated that intranasal administration of two doses of synthetic LH-RH induced luteolysis and controlled the occurrences of menses in normal women. Bergquist *et al.*[6] reported that in 27 regularly menstruating women once-daily intranasal administration of synthetic LH-RH inhibited ovulation in all but two of eighty-nine treatment months. Failures were claimed due to technical problems with nasal spray bottles. Twenty-one of the twenty-two women had slight menstrual-like anovulatory bleeding during the three- to six-month treatment period. The remaining six women were amenorrheic. Ovulatory menstrual cycles returned after discontinuing treatment.

There were no serious side effects observed from intranasal administration of synthetic LH-RH.[5,6] Some women experienced temporary local nasal irritation. Others had symptoms of common cold during the treatment period. Short-lived headaches were reported by several women during the first week of treatment.

In conclusion, intranasal administration of synthetic analogues of LH-RH appears to represent a new and potentially important approach to fertility control.

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2. Do you have any information concerning orgotein, a drug with superoxide dismutase activity?

Orgotein (sold as Palosein®), a water-soluble protein derived from various mammalian tissues, is a veterinary product administered parenterally with pronounced anti-inflammatory action. It appears to exert its effectiveness by a different mechanism of action than other anti-inflammatory drugs, and in part as a result of pronounced superoxide dismutase activity.[1] The drug is under investigation in man for treatment of inflammatory conditions of the bowel and bladder following radiation therapy, inflammatory conditions of the urinary tract and for degenerative joint diseases.[1-4]

Lund-Olesen and Menander[2] conducted a study utilizing orgotein intra-articularly into the knees and/or hips of 22 patients with degenerative joint disease. Treatment was evaluated by following pain, at rest and on motion, circumference of knees, range of motion, and overall patient status, both during and after therapy. Of 19 patients with sufficient followup, 16 experienced benefits for more than 90 days after termination of treatment.

Marberger *et al*[3] treated 22 patients with radiation cystitis, utilizing orgotein intramurally. Evaluation included cystoscopy and voiding volume, as well as loss of pain,

*The Center serves as a source of intelligence on therapeutic and pharmaceutic information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists: Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Arnold and Marie Schwartz College of Pharmacy and Health Sciences, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 5 p.m.—telephone (212) 622-8989 or 330-2735. Responses to these questions were prepared by J.M. Rosenberg, Ph.D., Pharm D.; H. Boothe, B.S. Pharm; G. Chishti, M. Pharm; P. Sangkachand, M.D., R.Ph.

spasms, dysuria, incontinence and hematuria. All patients responded well to orgotein therapy, but two patients required more than four injections to reach the "much improved" status.

Edsmyr *et al*[4] conducted a double-blind, placebo-controlled study utilizing orgotein parenterally in 42 patients who received radiation therapy for bladder tumors. Parameters evaluated were signs and symptoms of radiation-induced inflammation in the bladder or bowel wall, both during and after termination of radiation. The results suggested that the drug effectively ameliorated or prevented the side effects associated with high energy radiation therapy of bladder tumors.

No serious side effects due to orgotein were observed under the conditions used in these preliminary studies.[1-4]

In conclusion, orgotein appears to be an effective and safe anti-inflammatory agent.

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3. Please supply information on the use of colchicine in the treatment of cirrhosis.

Colchicine has been used for centuries for the treatment of gout.[1] Recently, there have been reports that it may be useful in the treatment of cirrhosis.[2-6]

Rojkind and Kershenobich[2] demonstrated that in carbon tetrachloride-treated rats, colchicine inhibited hepatic fibrosis and improved liver function.[2] Rojkind *et al*[3] also reported that colchicine improved the clinical course of seven severely ill cirrhotic patients. After two weeks of treatment with one to two mg of the drug per day, all patients showed striking clinical improvement and in five out of the six patients with hyperbilirubinemia, levels reverted to near normal.[3]

In a double-blind, randomized trial of 28 cirrhotic outpatients who completed 24 months of treatment with colchicine (1 mg/day/5 days/week) or placebo, all patients on colchicine were alive and without ascites or edema.[4] There were no bleeding episodes in the drug-treated patients and they exhibited a significant decrease in gamma globulins with maintenance of normal albumin levels. Only one subject exhibited encephalopathy. In contrast, no clinical improvement was seen in the placebo group and two patients died of complications of cirrhosis.

Kershenobich *et al*[4] in a double-blind, randomized controlled trial involving 43 cirrhotic patients, administered placebo to 20 patients while the others received colchicine (1mg/day/5 days/week). Four patients died in the colchicine-treated group compared to eight treated with placebo, but this difference was not statistically significant. Six colchicine survivors improved clinically with disappearance of ascites, edema and decreased spleen size.[1] A decrease in liver fibrosis as shown by serial biopsies occurred in several colchicine-treated patients. The placebo survivors continued to deteriorate. In several other studies, Kershenobich *et al*[5-6] demonstrated that colchicine appeared to enable patients with cirrhosis to maintain or increase their serum albumin in contrast to placebo. It was suggested that the beneficial effects of colchicine in cirrhosis may involve inhibition of collagen biosynthesis and its tissue deposition.[5]

The only side effect of colchicine mentioned in the various studies was transient diarrhea.[2-6]

In conclusion, it appears that primarily one group of investigators demonstrated a beneficial effect of colchicine in the treatment of cirrhosis. This should be explored further as perhaps it may offer a new and useful approach to the treatment of this condition.

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PEDIATRIC BRIEFS

Selected Abstracts with Comments*

Saywell RM, et al: A performance comparison: USMG—FMG house staff physicians. *Am J Pub Health* 70:23, 1980.

Over 3000 audits of histories and physical examinations were done in 14 hospitals on U.S. medical graduate (USMG) and foreign medical graduate (FMG) residents. Results revealed no significant difference in quality of these records. Differences did exist in quality from hospital to hospital. ". . . the charge of inferior care levelled against FMGs is not supported."

Comment: FMGs are likely to require time to get over "language problems and cultural shock." Despite these difficulties, objective assessment of their work reveals parity with USMGs. It may be that the tools of measurement are crude or that some of us equate finesse with adequacy of care. In any event, the myth that FMGs are less well qualified than USMGs needs to be revealed. It is a myth. The major difference, I believe, is in the FMGs cultural reticence. USMGs are more likely to ask questions, to challenge, to teach juniors without being encouraged. All of these traits are "likeable," and their absence seemingly undesirable. These traits must be separated from quality of care, however, and studies by Saywell and others like Knobel are very helpful in providing perspective.

Fujiwara T, et al: Artificial surfactant therapy in hyaline membrane disease (HMD). *Lancet* 1:55, 1980.

A mixture of naturally occurring surfactant lipids and synthetic lipids was instilled into the lungs of 10 severely ill newborns with HMD. Substantial improvement was noted in all.

Comment: This mixture, previously tested in animals, seems to be safe and, in this *very* preliminary study, effective. Much more experimentation needs to be done but this is a promising new approach to the treatment of HMD.

Lee KS, et al: Neonatal mortality, an analysis of recent improvement in the U.S. *Am J Pub Health* 70:15, 1980.

The two primary components which determine neonatal mortality are 1) birthweight distribution (percent of low birthweight) which is affected by socioeconomic status, parity and medical complications of pregnancy and 2) birthweight specific mortality (mortality at each birthweight) which is affected by perinatal care and gestational age. In a review of 25 years of national statistics it was found that birthweight distribution had not changed over this period but birthweight specific mortality had improved and accounted for nearly all of the improvement in neonatal mortality rates. The reason for this improvement is probably an improvement in perinatal medical care (neonatal intensive care; regionalization of care) since other factors which affect survival at a given birthweight have not changed. The absence of a favorable change in birthweight distribution is troubling and needs intensive analysis.

Comment: Neonatal intensive care and its spinoffs are improving neonatal mortality at each birthweight, but low birthweight, a problem which is more socioeconomic and cultural than medical, has not changed. Low birthweight itself is the major determinant of neonatal mortality.

Seibert JJ: Excretory urography for evaluation of enuresis. *Pediatr* 65:A49, 1980.

The Committee on Radiology of the American Academy of Pediatrics states: "Routine radiologic studies are not indicated for enuretic children with normal urine analysis and cultures; normal physical examinations, including the external genitalia; and no evidence of neurologic disease." If enuresis is associated with proven urinary tract infection (and it often is), radiographic examination is reasonable. True incontinence does require radiographic examination.

Comment: One way to reduce overuse of technology is not to do tests that aren't necessary.

Merten DF: Comparison radiographs of extremities in childhood. *Pediatr* 65:A57, 1980.

The Committee on Radiology of the A.A.P. states: ". . . the routine use of comparison views of the uninjured extremity does not, with but few specific exceptions, appear to be justified and should be discontinued."

Comment: Ditto.

Staheli LT, et al: Corrective shoes for children. *Pediatr* 65:13, 1980.

Many pediatricians prescribe special shoes for intoeing, flat feet, bow legs, knock knees and even for normal feet. There is no evidence of value of these shoes. In fact, shoes need only be flexible and protective and tennis shoes for children are reasonable. Infants may need high flexible shoes so they will stay on. The flexible flat foot is not abnormal and needs no treatment; flexible metatarsus adductus should only be treated if persistent (casts); intoeing needs treatment only if severe and persistent (night splints or heel ties); bow legs

*Abstracted from "Children's Hospital Newsletter," United Hospitals of Newark, Vol. 2, No. 2 (February 1980). Selections are made and original comments prepared by Richard H. Rapkin, M.D., Medical Director, and members of the medical and surgical staff.

and knock knees are usually normal developmental processes.

Comment: "Leave the child alone."

Simons FER, et al: Theophylline Toxicity in Term Infants. *Am J Dis Child* 134:39, 1980.

Theophylline given to one-month-old term infants has different pharmacokinetics than in older children. It has not been studied objectively for treatment of wheezing in this age group and should not be used "until its efficacy is proved or disproved and the range of effective serum concentrations and the pharmacokinetics are defined . . ."

Comment: Treatment of bronchiolitis in infants is difficult enough without adding the complexity of drugs that have not been well studied.

Rapin I: Conductive Hearing Loss. Effects on Children's Language and Scholastic Skills. *Ann Otol Rhin Laryng* 88: (Suppl.) 3, 1979.

A review of the literature has failed to discover a rigorous study of the effect of conductive hearing loss on language and schooling, although "the burden of evidence is that persistent mild hearing loss, especially if present since infancy, probably has a measurably deleterious effect on the language of most but not all children." The effects may be more marked in the culturally deprived. Whether hearing losses of less than 25 dB are significant is unknown; the duration of the "significant" hearing loss is also unassessed.

Comment: Otitis media leads to or results from eustachian tube dysfunction in a large proportion of infants. Such dysfunction affects hearing. Such hearing loss *may* affect learning. How does one treat persistent eustachian tube dysfunction? The answer is related to its significance and the possible deleterious effects of the treatment. Although many of us act as if we knew the answers (tympanocentesis, tympanostomy tubes, adenoidectomy, etc.) we really don't.

Magnus, PD, et al: The Paucity of Breast Feeding in an Urban Clinic Population. *Am J Pub Health* 70:75, 1980.

Only 10 percent of lower socioeconomic group babies in Los Angeles are breast fed. This is substantially less than middle and educated classes where a renaissance in breast feeding appears to have begun. These lower socioeconomic group children are more apt to benefit from breast feeding than others. Peer advocacy and well baby and lactation clinics may help to alter these practices.

Sarnaik S, et al: Periodic Transfusions for Sickle Cell Anemia (SCA) and CNS Infarction. *Am J Dis Child* 133:1254, 1979.

Vaso-occlusive crises in SCA that involve the CNS can be devastating. Recurrences of CNS involvement occur in 30 to 70 percent. Periodic transfusions of Hemoglobin A cells to keep the hemoglobin at 10 to 12 are effective in reducing (nearly eliminating) such recurrences. The risk of transfusion hemosiderosis must be weighed, but the value of desferioxamine (continuous SQ infusion) for iron removal reduces that risk.

Selby PJ, et al: Parenteral Acyclovir Therapy for Herpesvirus Infections in Man. *Lancet* 2:1267, 1979.

Acycloguanosine (acyclovir) was used to treat almost two dozen patients with herpes simplex or varicella-zoster infections. The drug has little or no toxicity and seemed efficacious.

Comment: This preliminary report of a new antiviral gives promise. Previously touted antivirals have rarely proved as valuable as first thought. The only agents currently of value for herpes simplex are idoxuridine (topical) and adenine arabinoside (ARA-A). The latter also has been used for varicella-zoster, as has interferon. Acyclovir should be watched closely.

McKeown T: The Direction of Medical Research. *Lancet* 2:1281, 1979.

"Most diseases are due to adverse environmental influences on people whose genes make disease more or less likely but not inevitable . . . the influences are of two kinds, deficiencies and hazards . . . of the four essentials of life—food, water, oxygen and heat—only food has been seriously deficient. The common hazards are from other living things competing for existence . . ." "Changes in the environment from the conditions under which man evolved create new hazards, from exposure to influences to which the genes are not adapted."

Comment: Dr. McKeown is a profound medical thinker and this excerpt is included to tempt you into reading the entire article in the December 15, 1979 issue of Lancet.

YOUR CONGRESSMAN SPEAKS

Health Care: Quality and Cost

THE HONORABLE BILL BRADLEY, Washington, D.C.

One of the most challenging tasks facing America is to improve the quality of health care while restraining its cost. This will not be achieved easily. National health expenditures consistently have surpassed price increases in the rest of the economy for decades and costs have nearly doubled in the past six years.

Many proposals have been made to stem this rise and increase health care efficiency. One which I strongly support is the formation of health maintenance organizations (HMOs), including Independent Practice Associations. Two features of these organizations are particularly attractive.

First, HMOs tend to improve health care through emphasis on preventive services and early intervention (as contrasted with hospital-based care which is inclined to focus on illness-intervention and crisis management). In addition, HMOs provide health education which encourages their members to take greater individual responsibility for their own health.

Second, HMOs can introduce a necessary and valuable element of competition into the health care system that can help to restrain rising costs. HMOs hold their own costs down through more efficient use of the health care "team" and through the practice of prospective budgeting, where costs must be made to fit within budgets set at the beginning of the year. Lower "premium" or membership costs to the individual can result from less wasteful choices about when to intervene in the progress of an illness and what procedures and medications to use.

For example, current data show that HMOs reduce hospital admissions for their members by 30 to 50 percent. This is not because HMO members are going without necessary hospital care or operations. By benefiting from the better use of outpatient services, second opinions and other HMO practices, their need for inpatient care has been reduced.

In spite of these two features, the federal government has been very slow to recognize and make greater use of HMOs in Medicare and Medicaid, the two large federal programs charged with providing some 51 million Americans with health care coverage. The federal employees' health plan offers the option of HMO membership as an alternative to Blue Cross/Blue Shield and private insurance. Yet the fee-for-service, hospital-based, cost-reimbursement bias in American medicine still dominates Medicare and Medicaid. The result is higher bills for government and, thus, for all taxpayers.

Currently, the federal budget allocates $37 billion for the federal Medicare program and $16 billion for the federal share of Medicaid costs. The Senate Finance Committee, of which I am a member, has jurisdiction over both of these programs. It is now considering how to allow more cost-saving flexibility into both programs and to encourage greater cost competition in these programs. Medicaid is being addressed in the context of our National Health Insurance deliberations, and I expect the committee to produce a bill providing for greater options in service delivery mechanisms for Medicaid recipients.

The administration last year proposed legislation which would create incentives for both Medicare beneficiaries and HMOs to increase enrollment of older Americans in HMOs. I am a cosponsor and strong supporter of this bill, the Health Maintenance Organization Medicare Reimbursement amendments of 1979. I believe these proposals hold the prospect of improving health care services for our Medicare population and lowering costs both to the elderly and to the federal government. New Jersey Medicare recipients—as residents of three high-cost medical areas—certainly would benefit from increased access to competitive health care delivery systems such as HMOs.

As the cost of health care has continued to escalate, few groups have been as vulnerable as the elderly. When the Medicare program was enacted in 1965, the aged faced out-of-pocket medical expenses averaging $237 a year. By 1967, Medicare payments reduced those average costs to $178, but ten years later, the average per capita, out-of-pocket medical expenses for the aged had shot up to $576 a year. Despite rapid growth in Medicare expenditures and the presence of other public programs, the elderly now must pay about 33 percent of health care costs out of their pockets.

Added to this financial hardship are the complexities of dealing with claim forms, finding appropriate specialists and knowing where to get care outside of normal office hours. These problems face most Americans, but they are especially burdensome for the aged.

The HMO-Medicare bill could help to ease these financial and logistical strains. Its objective is to involve HMOs to a much greater degree in enrolling Medicare beneficiaries. A

*United States Senator from New Jersey. He is a member of the Senate Committees on Finance and on Energy and Natural Resources and the Special Committee on Aging. He may be addressed at 4104 Dirksen Building, Washington, D.C. 20510

typical HMO provides a broad array of high-quality health benefits for a prepaid fee. The HMO member's financial participation is specified at the outset. This pre-determined limit on HMO revenues creates incentives for efficient management and the avoidance of unnecessary care.

Current law does little to encourage Medicare enrollment in HMOs. Enrolled beneficiaries do not gain from their choice of a more efficient health care delivery system. Nor do HMOs have any incentive to seek out Medicare beneficiaries. As a result, less than two percent of the Medicare population is enrolled in HMOs.

Under the legislation that the administration introduced, and I cosponsored, greater participation by HMOs in Medicare would be encouraged. It would provide prospective payments to an HMO for its Medicare members at 95 percent of the fee-for-service rate for the area. The HMO would be required to apply any difference between the 95 percent and its average premium, adjusted for Medicare, to finance the following benefits for Medicare patients: preventive services; reduced deductibles; coinsurance and other copayments; and additional non-covered services, such as dental services and prescription drugs.

Of course, there are problems and unresolved issues about HMOs that will require continued study, review and adjustment. For instance, HMOs need to assume a greater responsibility for providing care to a balanced mix of the community's high-risk citizens. HMOs also must avoid achieving dollar savings at the cost of unacceptably high waiting times and service delays. And HMOs must continue to seek innovative approaches to health care delivery, thereby maintaining their competitive edge.

HMO development is receiving broad support from labor and business groups and from many in the health care industry. Private investments are on the increase, reducing HMO dependence on government funding. A recent HEW report on operating HMOs showed that 121 out of 217 organizations were developed solely with private funds. Another 100 HMOs currently in the process of organizing were developing without federal assistanmce while 80 were being supported with federal aid. Private investment of this type is a reassuring non-governmental response to societal needs.

The percentage of the population enrolled in HMOs is still small and HMOs will continue to be only one component in our pluralistic health care system. But I firmly believe that they and other innovative approaches to providing health care have substantial contributions to make to the cost effectiveness and accessibility of health care in America.

DOCTOR'S NOTEBOOK

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

Of the new M.D.'s who completed their education at CMDNJ, the largest group in the College's history—155 of the total 326 this year—have joined the housestaffs of New Jersey hospitals.

This increase in the number of new physicians staying in New Jersey for residency programs comes in spite of a dramatic increase in the number of graduating medical students entering military service services. Of CMDNJ's graduating class in May, 23 have signed up to take postgraduate training at armed forces facilities, compared to six in the class of 1979. The rise in students entering the armed forces is significant, since the total electing for military service never has exceeded ten since the College was founded in 1970. However, it's a predictable trend considering the state of the economy and the rising costs of medical education. Those who joined the armed forces during medical school are not faced with the heavy burden of huge education loans upon graduation.

It is gratifying, however, to see that the emerging pattern has not affected the continuing trend toward larger numbers of New Jersey-born and New Jersey-trained physicians remaining in the State to continue their training. The 155 graduates who will do so represent half of those who are taking postgraduate training at civilian institutions. This number has been rising steadily since 1970, when only 21 New Jersey medical graduates, about one third of the class, remained in the State for postgraduate training. Last year, 141 CMDNJ-trained physicians chose New Jersey residencies, about 46 percent of those joining non-military hospitals.

The 326 new physicians who completed their training programs this tenth anniversary year of CMDNJ included 126 graduates of the CMDNJ-New Jersey Medical School, Newark; 91 graduates of the CMDNJ-Rutgers Medical School, Piscataway, and 109 physicians in the Fifth Pathway program which provides a year of intensive clinical training to American graduates of foreign medical schools.

At the commencement exercises it was most appropriate, as well as personally satisfying, that the College recognized the contributions of John K. Kittredge, executive vice president of the Prudential Insurance Company of America, and first chairman of the CMDNJ's Board of Trustees—a position he held for over seven years—by awarding him an honorary doctor of science degree during CMDNJ's tenth anniversary year. His able and tireless leadership was a key factor in nurturing the College through its formative years and in guiding it through the strains of rapid growth and development. Under his leadership, CMDNJ built a major campus, added two new schools, tripled enrollment and developed into a State-wide network for health sciences education, research and service.

TENTH ANNIVERSARY

On the subject of the College's tenth anniversary, plans are progressing for a gala celebration scheduled for November 15 at Princeton University. We hope many physicians and other friends of CMDNJ will join us in this evening of fun and friendship. The black-tie affair will honor the State's governors who were instrumental in the creation and growth of CMDNJ, which now comprises six schools, two teaching hospitals and two community mental health centers. In addition to Governor William T. Cahill, who signed Assembly Bill No. 1059 on June 16, 1970 to create CMDNJ, they are Governor Robert B. Meyner, Governor Richard J. Hughes and Governor Brendan T. Byrne.

Serving as co-chairman of a blue-ribbon executive committee of leaders in business industry and health care professionals arranging the affair are Robert A. Beck, chairman of the board and chief executive officer, Prudential Insurance Company of America, and James E. Burke, chairman of the board, Johnson & Johnson.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

In the June, 1980 issue of this *Journal*, the interest of the Foundation in the care of the elderly was described. This evolved from the difficulty in finding long-term care placement for patients in acute care hospitals. On any given day, more than 1,000 such patients are awaiting transfer. This, of course, affects utilization review results. These results are often beyond the control of the PSRO. The New Jersey Professional Standards Review Council charged the Foundation with the task of investigating this problem. A Committee on Management of the Aged, chaired by Dr. William A. Dwyer, has studied the problem in depth. In the interest of the health and care of our senior citizens, the Committee did not confine its attention to hospitals and other institutions for the ill and infirm. Its recommendations cover a number of problems affecting the elderly, and projects to be considered. The suggested projects include the following:

SCREENING PROGRAM

It is envisioned that senior citizens would be screened either upon retirement or otherwise to detect various health and social problems. Regarding health problems, it is recommended that the local medical community can be the key in coordinating various services which are now in existence.

COMMUNITY CENTERS

Senior citizens will be screened and provided the opportunity to enjoy services provided at these centers. The creation and management of such centers should be a local community responsibility. The anticipated problem is one of legislation that is needed in New Jersey to provide monies for such community centers. A job description should be developed to organize matters in this direction.

PSRO NURSING HOME REVIEW

This category stems from PL92-603

and the inability in 1980 for future implementation. It is projected that a system be developed to carry out review of nursing homes in New Jersey by competent and professional review organizations. This would require the organization, assignment, financial support, and the development of such a system. The cooperative effort of all parties is needed due to the lack of a federal and state mandate.

REHABILITATION PROJECT

This project needs a great deal of definition. Schematically it is directed for rehabilitation potential to patients with failing diseases. The concept is coordinating and collating available resources within the community under the guidelines of a physician organization. The overall goals will be the availability to patients to return to a home setting.

HOSPICE DEVELOPMENT

A great social problem confronting Americans in the 1980s will be death with dignity. The concept of hospice is one which is spreading rapidly in the United States. This has been recognized by the secretary of HHS as a priority of that department. The investigation, exploration and study will be one taken on by the Management of the Aged Committee. As with other projects, a plan of action must be identified.

DATA ACCUMULATION

The ability to collect information on all projects will be one pursued by this committee. A backlog of information will assist us in making determinations and providing reliable answers to the questions for all of our projects.

The Foundation has formed a Council on the Management of the Aged. The Council will carry on the work begun by Dr. Dwyer's Committee and will pursue that Committee's recommendation. The deliberations will involve all concerned with the elderly, who constitute a significant portion of the population of New Jersey. Alternatives to the nursing home deserve much attention. Home health care, community day care centers, and involvement of the families of senior citizens are examples. The hospice concept for the severely ill is gaining attention. Better methods of rehabilitation for those who need it should be provided. The tendency, in some facilities, to tranquilize their patients should be reevaluated.

Not all elderly citizens are ill or disabled, or "senile." Many will not fit into any "diagnostic" category, since they exhibit only biological effects of time. There are people in nursing homes who do not need to be there. Dr. Bruce Vladeck, Assistant Commissioner of Health of New Jersey, estimates that there are 30,000 patients in nursing homes in our State. Most of these are in the senior group. Dr. Vladeck has written a thoughtful and provocative book on nursing homes which is worthy of your attention.[1]

These projects are a sample of a series developed because of concerns over what appear to be cold statistics. Such figures—how many patients can or cannot be placed in a long-term facility—should be analyzed not only in terms of costs to payers, but in relation to improving the status of our older fellow citizens.

The project will be reported as it proceeds. Suggestions and comments will be welcomed at the Foundation office.

[1]Vladeck BC: *Unloving Care: The Nursing Home Tragedy*. New York, Basic Books, 1980.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Mohammed Mushtaque, M.D., 183-11 Hillside Ave., Apt. 11-K, Jamaica, NY 11432. Dow (Pakistan) 1975. Board eligible. Group, solo, or institutional. Available.

Narciso J. Samuy, M.D., 1180 East and West Road West, West Seneca, NY 14224. Santo Tomas (Philippines) 1970. Board eligible. Group or partnership. Available.

Peter J. Arches, M.D., 150 Fayette Avenue, Apt. 2-H, Staten Island, NY 10305. University of East (Philippines) 1969. Board eligible. Group practice. Available.

DERMATOLOGY—Ellen Blank, M.D., 1675 York Avenue, New York, NY 10028. Mt. Sinai 1975. Board certified. Any type practice. Available.

Karen Kade, M.D., 38 Fidelity Court, Carrboro, NC 27510. Albert Einstein 1976. Board eligible. Multi-specialty group. Available.

FAMILY PRACTICE—Kuchibhotla M. Krishna, M.D., 4309 West 95th Street, Apt. #23, Oaklawn, IL 60453. Andhra (India) 1970. Clinic practice or hospital-based practice without calls or weekends. Available January 1981.

GASTROENTEROLOGY—Michael F. Fina, M.D., 134 North Street, Apt. 7, Newtonville, MA 02160. New York Medical College 1975. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available.

Abbasi Akhtar, M.D., 333 East Ontario Street, Apt. 1512-B Chicago, IL 60611. Liaquat (Pakistan) 1966. Also, general internal medicine and pediatric gastroenterology. Board eligible. Any type practice. Available September 1980.

GENERAL PRACTICE—Gregory A. Pistone, M.D., 2018 High Street, Haddon Heights 08035. Pennsylvania State 1979. Board eligible. Student health/adolescent medicine, pharmaceutical, ER, house physician. Available.

James Walter Warren, M.D., 67 Welton Street, New Brunswick, NJ 08901. Meharry 1973. Also general internal medicine. Any type practice. Available.

Chandrakant Patel, M.D., 4855 Vezina, Apt. #14, Montreal, Quebec H3W 1BQ Canada. Gandhi (India) 1970. Group, partnership, or solo. Available.

HEMATOLOGY/ONCOLOGY—P.S. Bala, M.D., 882-6 Clifton Court Circle, NE, Atlanta, GA 30329. Calicut (India) 1965. Board eligible. Any type practice. Available.

INTERNAL MEDICINE—Jay I. Lipoff, M.D., 3188 Skinner Mill Road, Apt. 9-G, Augusta, GA 30909. NYU 1975. Also, cardiovascular diseases. Board certified. Group or partnership. Available.

Omprakash B. Ramani, M.D., 61-15 98th Street, Apt. 17-F, Rego Park, New York 11374. B. J. Medical (India) 1973. Board certified. Group or partnership. Available.

Stuart R. Schlanger, M.D., 105 North 31st Avenue, Omaha, NE 68131. Washington University 1977. Special interest, emergency medicine. Board eligible. Group or partnership. Available.

Richard Plotzker, M.D., 79 Holbrook Road, North Quincy, MA 02171. St. Louis University Board eligible. Group, clinic, institutional, or industrial. Available.

Khadar Baig, M.D., 2681 Arlington Drive, Apt. 303, Alexandria, VA 22306. Andhra (India) 1971. Subspecialty, gastroenterology. Board certified. Any type practice. Available.

Douglas R. Shumaker, M.D., 7861 Jefferson Street, Hummelstown, PA 17036. George Washington University 1977. Partnership, single or multi-specialty group, solo, emergency room. Available.

Joel M. Cohen, M.D., 1131 University Boulevard West. Apt. 1404, Silver Spring, MD 20902. SUNY-Downstate 1975. Subspecialty, cardiovascular diseases. Board certified. Single or multi-specialty group, partnership. Available.

Sybil Kramer, M.D., 68 Winchester Street, Brookline, MA 02146. SUNY-Downstate 1975. Subspecialty, endocrinology. Board certified. Single or multi-specialty group, partnership. Available.

Mark L. Friedman, M.D., 2901 S. King, Apt. 1003, Chicago, IL 60616. University of Chicago 1977. Subspecialty, emergency medicine. Single or multi-specialty group, partnership. Available.

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Richard L. Rudolph, M.D., 124 Pearl Street, Red Bank 07701. CMDNJ 1976. Board eligible. Single or multi-specialty group, partnership. Available.

Robert H. Gordon, M.D., 5500 Wissahickon Ave., Apt. 405-C, Philadelphia, PA 19144. Jefferson 1975. Subspecialty, rheumatology. Board certified. Any type practice. Available.

Laurence J. Clark, M.D., 5038 Cliffhaven Drive, Annandale, VA 22003. Georgetown 1975. Subspecialty, emergency medicine. Partnership, solo, emergency room. Available.

Devi P. Misra, M.D., 7K University Terrace, Columbia, MO 65201. SCB Medical College (India) 1967. Subspecialty, pulmonary medicine. Board certified. Solo, institutional, group. Available.

Jon Allen Kotler, M.D., c/o Dept. of Medicine, 1356 Lusitana Street, Honolulu, HI 96813. Emory 1976. Subspecialty, emergency medicine. Board eligible. Single or multi-specialty group, partnership. Available.

Howard L. Kramer, M.D., 4 Longfellow Place, Apt. 803, Boston, MA 02114. Florida 1975. Board certified. Single or multi-specialty group, partnership. Available.

Mirza M. Ashraf, M.D., West St. Road, Carthage, NY 13619. King Edward (Pakistan) 1967. Subspecialty, cardiovascular diseases. Solo, single-specialty group, institutional. Available.

Mohamed M. Haq, M.D., 10555 Fondren, Apt. 422, Houston, TX 77096. Osmania (India) 1973. Subspecialty, neoplastic diseases. Board certified. Single or multi-specialty group, research. Available.

Betty J. Barcevac, M.D., 2795 Shore Parkway, Apt. 1-G, Brooklyn, NY 11223. Guadalajara (Mexico) 1976. Group, partnership, single or multi-specialty group. Available.

Robert Lebow, M.D., 77 Grove Street, Montclair 07042. SUNY-Downstate 1977. Board eligible. Academic, partnership, multi-specialty group, industrial. Available.

Ira E. Kaplan, M.D., 523 East 14th Street, New York, NY 10009. SUNY-Downstate 1976. Special interest, cardiology. Board certified. Group, partnership. Available.

Hyung G. Kim, M.D., 1834 Beacon Street, Washington CH, OH 43160. Yonsei (Korea) 1970. Subspecialty, cardiology. Board certified. Group, partnership, or hospital-based practice. Available.

Akbar H. Obaray, M.D., 61-20 Grand Central Parkway, Apt. A-1407. Forest Hills, NY 11375. Grant (India) 1972. Subspecialty, pulmonary medicine. Board certified. Solo, group, or partnership. Available.

Bharat B. Parikh, M.D., 41-06 75th Street, Apt. 2, Elmhurst, NY 11373. Baroda (India) 1973. Subspecialty, pulmonary medicine. Board eligible. Solo or guaranteed group practice possibly leading to partnership. Available.

Fred Lewis, M.D., 7 Peter Cooper Road, Apt. 8-F, New York, NY 10010. Albany 1971. Subspecialty, endocrinology. Board certified (both). Group or hospital-based practice. Available.

Edward Lebowitz, M.D., P.O. Box 349, Lake Placid, NY 12946. SUNY-Downstate 1963. Board eligible. Group or partnership. Available.

Robert Fulop, M.D., 2678 Ocean Avenue, Apt. 5-E, Brooklyn, NY 11229. SUNY-Upstate 1978. Board eligible. Solo, partnership, group, or association. Available July 1981.

Joclekar S. Shankar, M.D., 9302 Cherry Hill Road, College Park, MD 20740. Grant (India) 1973. Board certified. Group, partnership, or hospital based. Available.

Byron S. Thomas, M.D., 513 Beachwood Court, Jacksonville, NC 28540. Pittsburgh 1975. Board certified. Group or partnership. Available November 1980.

Irwin Jaffe, M.D., 189-B Newport Road, Cranbury, NJ 08512. Zurich 1934. Board certified. Full or part-time industrial medicine or part-time with group. Available.

Peter Buch, M.D., 69-91 113th Street, Forest Hills, NY 11375. SUNY-Downstate 1976. Special interest, gastroenterology. Board certified. Group or partnership. Available July 1981.

Tej Mathur, M.D., 3071 Edwin Avenue, Apt. 3-C, Fort Lee, NJ 07024. Osmania (India) 1969. Special interest, cardiology. Group, partnership, solo. Available.

NUCLEAR MEDICINE—Philip A. Bardfeld, M.D., 160 West End Avenue, Apt. 8-E, New York, NY 10023. SUNY-Downstate 1961. Board certified. Single or multi-specialty group, institution. Available.

OBSTETRICS/GYNECOLOGY—Lemuel G. Villaneuva, M.D., 173 Lionhead Court, Baltimore, MD 21237. University of East (Philippines) 1974. Board eligible. Solo, group, HMO associate, hospital-based. Available.

Mina M. Chudgar, M.D., 15427 Jester Avenue, Baton Rouge, LA 70816. B.J. Medical College (India) 1972. Board eligible. Group, partnership. Available.

Mohammad Imtiaz Ahmad, M.D., 677 Central Avenue, Barboursville, WV 25504. Pakistan 1970. Board eligible. Solo with coverage when needed, small town. Available.

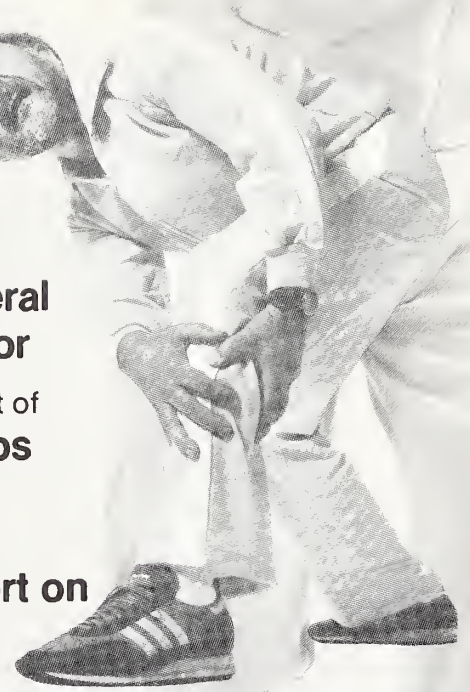
ONCOLOGY—Kumud S. Tripathy, M.D., 14 Slate Creek Drive, #5, Cheektowaga, NY 14227. P.W. Medical (India) 1972. Also, general internal medicine. Board certified (IM). Solo, group, institution-based, or partnership. Available.

Pradeep S. Mahal, M.D., 12415 Newbrook Drive, Houston, TX 77072. All-India 1974. Also, general internal medicine. Board certified (IM). Solo, single or multi-specialty group, partnership. Available.

OPHTHALMOLOGY—Ronald A. Serniuk, M.D., 502 Thompson Avenue, Roselle, NJ 07203. Georgetown 1971. Board eligible. Partnership or solo. Available.

Mitchell Schuman, M.D., 1675 York Avenue, New York, NY 10018. New York Medical 1975. Board eligible. Any type practice. Available.

Edward A. Pulice, M.D., 49-20 Hanford Street, Apt. #1, Douglastown, NY 11362.



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NYU 1976. Group, partnership, solo. Available.

PATHOLOGY—Uma Raghavan, M.D., Dept. of Pathology, Norwalk Hospital, Norwalk, CT 06850. Delhi (India) 1973. Both AP/CP. Board certified. Group. Available.

Joseph V. Napolitano, M.D., 7 Howland Road, Middletown, NJ 07748. Bologna (Italy) 1972. Special interest, anatomic and clinical pathology. Board certified (both). Institutional, group, or partnership. Available.

Doroteo A. Vicente, M.D., 36976 Farmbrook Drive, Mt. Clemens, MI 48043. Santo Tomas (Philippines) 1972. Both AP/CP. Board eligible. Group or partnership. Available.

PEDIATRICS—Norma P. Samuy, M.D., 1180 East and West Road, West Seneca, NY 14224. Santo Tomas (Philippines) 1970. Board eligible. Solo, partnership, clinic. Available.

Soni Mahesh, M.D., 100 Hospital Plaza, #811, Paterson 07503. Baroda (India) 1973. Board eligible. Partnership or solo. Available.

Nathaniel D. Wycliffe, M.D., 1563 Boston Avenue, Bridgeport, CT 06610. Dacca (Pakistan) 1972. Board certified. Group, solo, associate. Available.

Sunila Mehrotra, M.D., 829 Main Street, Apt. C, Belleville, NJ 07109. Delhi (India) 1974. Board eligible. Group/partnership. Available July 1981.

David R. Croughan, M.D., 12 Harbor Boulevard, East Hampton, NY 11937. Guadalajara (Mexico) 1973. Board eligible. Group, partnership. Available.

PSYCHIATRY—Charles Goldfarb, M.D., 121 Deerhaven Road, Mahway 07430. Buffalo 1956. Board certified. Partnership in single or multi-specialty group. Available.

Paul L. Maitheny, M.D., 99 Pawnee Road, Lakewood, NJ 08701. Graz (Austria) 1951. Board eligible. Any type practice. Available.

Ahmed Naimetulla Syed, M.D., 3430 Kay Street, Apt. D-11 Colony East, Columbia, SC 29210. Kakatiya (India) 1971. State hospital, university, institution, or correction center. Available.

PULMONARY DISEASES—Susan Kallos Sekely, M.D., 7528 Arlington Expressway (220), Jacksonville, FL 32211. Budapest U. of Med. Sciences 1952. Board certified. Hospital, group, or state institution. Available.

Krishna Rao, M.D., 1575 Boston Avenue, Apt. C-9, Bridgeport, CT 06610. Osmania (India) 1973. Also general internal medicine. Board certified. Solo, group, hospital, partnership. Available.

RADIOLOGY—Donald S. Cohen, M.D., 1089 Briar Way, Fort Lee 07024. Guadalajara (Mexico) 1975. Board eligible. Group, partnership, solo (will consider purchase). Available.

Bernard S. Jay, M.D., Box 1356, Madison, CT 06443. Georgetown 1971. Special interest, diagnostic radiology. Also, general internal medicine. Board certified. Group or hospital-based (shore areas), all aspects of ultrasound. Available.

SURGERY, GENERAL—B. Paulauskas, M.D., 5700 Arlington Avenue, Apt. 2-K, Riverdale, NY 10471. Lithuania 1972. Board eligible. Group, partnership, solo. Available.

Mohan Lal Sarwal, M.D., 42-52 Union Street, Apt. 117, Flushing, NY 11355. Govt. Medical, Patiala-Punjab (India) 1968. Group, partnership, solo. Available.

Mohammad A. Arain, M.D., 3420 Deanza Avenue, Merced, CA 95340. Liquat Medical (Pakistan) 1969. Board eligible. Partnership, single or multi-specialty group. Available.

Ranvir S. Achreja, M.D., 2400 Southloop West, #1502, Houston, TX 77054. MGM Medical (India) 1969. Board eligible. Solo, single or multi-specialty group. Available.

Gary G. Wind, M.D., 6202 Singleton Place, Washington, DC 20034. Temple 1970. Special interest, colon and rectal surgery. Board certified. Single or multi-specialty group, research. Available.

Joseph Dotan, M.D., 1206 East 49th Street, Brooklyn, NY 11234. Hebrew University (Israel) 1966. Special interest, oncology. Board eligible. Multi-specialty group, research, partnership. Available.

Ronald H. Sultan, M.D., 7750 Roosevelt Boulevard, Eden Roc Apt. 216, Philadelphia, PA 19152. NYU 1973. Special interest, abdominal surgery. Board eligible. Partnership, solo, single-specialty group. Available.

Nirmal E. Pathak, M.D., 324 Seminole Drive, Montgomery, AL 36117. N.R.S. Medical (India) 1963. Board certified. Any type practice. Available.

Michael S. Weingarten, M.D., Henry Ford Apartments, 1350 W. Behune Ave., Apt. 1207, Detroit, MI 48202. Columbia 1974. Board eligible. Single or multi-specialty group, partnership. Available.

Nardo T. San Diego, M.D., 171 Davis Avenue, Piscataway, NJ 08854. Far Eastern (Philippines) 1961. Board eligible. Solo or partnership. Available.

Seeplaputhur G. Sankar, M.D., 128 Normandy Drive, Norwood, MA 02062. Prince of Wales (India) 1974. Special interest, vascular surgery. Board eligible. Group, partnership, solo. Available.

Jung T. Tsai, M.D., 240 Willoughby Street, Apt. 8-D, Brooklyn, NY 11201. China Medical 1971. Board eligible. Solo, partnership, group. Available.

Absalon Gutierrez, M.D., 1925 Pacific Avenue, Atlantic City, NJ 08401. Nicaragua 1972. Board eligible. Group or emergency room. Available.

Jeffrey E. Lavigne, M.D., 1591 North Van Buren Avenue, Ottumwa, Iowa 52501. SUNY-Downstate 1970. Also, peripheral vascular surgery. Board certified. Any type practice. Available.

Juanilito N. Seldera, M.D., 4114 Ninth Avenue, Brooklyn, New York 11232. Univ. of East (Philippines) 1972. Special interest, surgical oncology. Board eligible. Group, partnership, solo. Available.

Ronald Bagner, M.D., 3450 Wayne Avenue, Apt. 24-A, Bronx, NY 10467. St. Louis 1974. Board eligible. Any type practice. Available.

Craig J. Schaefer, M.D., 2507 North Upton Street, Arlington, VA 22207. Albany 1974. Board eligible. Group, solo, partnership. Available July 1981.

SURGERY, ORTHOPEDIC—Joseph D. Jannuzzi, M.D., P.O. Box 6012, Lake Charles, LA 70606. Wayne State 1962. Board certified. Partnership, single or multi-specialty group. Available.

SURGERY, PLASTIC—Edmond B. Cabbabe, M.D., 5064 Clairidge Drive, Apt. 214, St. Louis, MO 63129. Damascus (Syria) 1972. Board eligible (general and plastic surgery). Solo or partnership. Available.

SURGERY, THORACIC—Louis T. Kanda, M.D., 12000 Edgewater Drive, Lakewood, OH 44107. George Washington 1970. Board certified (general surgery). Group, partnership, institutional. Available.

Khalid Y. Khan, M.D., 8 Gulf Lane, Galveston, TX 77550. King Edward (Pakistan) 1970. Also, general surgery. Board eligible (general surgery). Solo, institutional, single-specialty group. Available.

Anne-Marie Régal, M.D., 708 Beach Avenue, Bronx, NY 10473. Boston 1970. Board eligible. Single-specialty group, partnership, or institutional. Available.

SURGERY, UROLOGICAL—Steven H. Paletsky, M.D., 841 Ridgeview Drive, Medina, OH 44256. Med. U. of SC 1973. Board eligible. Partnership, solo, single-specialty group. Available.

Marc B. Osias, M.D., 12205 Morocco, NE, Albuquerque, NM 87111. Yale 1972. Board eligible. Partnership, single or multi-specialty group. Available.

William A. Mandour, M.D., 149 Elm Drive, Rochester, NY 14609. Loyola-Stritch 1974. Partnership, single or multi-specialty group. Available.

Harry F. Reiss, M.D., 2100 East Chester Road, Apt. 2-K, Bronx, NY 10461. Guadalajara 1973. Board eligible. Single or multi-specialty group, partnership. Available.

Sidney Goldfarb, M.D., 305 E. 24th Street, New York, NY 10010. Einstein 1975. Single or multi-specialty group, partnership, solo. Available.

UROLOGY—G. Rosenberg, M.D., 205 West 15th Street, New York, NY 10011. NYU 1974. Board eligible. Partnership, group, solo, multi-specialty group. Available.

Balakrishna Sundar, M.D., 912 Parkview Lane, Des Plaines, Illinois 60016. Maulana Azad (India). Board eligible. Group, partnership, solo. Available.

Eliahu Koren, M.D., 5700 Arlington Avenue, Apt. 6-J, Riverdale, NY 10471. Jerusalem 1968. Board eligible. Group, partnership, solo. Available.

Vijay S. Athani, M.D., 2009 Trent Court Apartments, Lindenwold, NJ 08021. L.T. Med. College (India) 1970. Board eligible. Solo, partnership. Available.

LETTER TO THE JOURNAL

They Are Out To Get Us

May 30, 1980

To the Editor:

To the uninitiated, we physicians may appear paranoid when discussing our relations with the legal profession, and the malpractice crisis.

On the other hand, a recent article in *The New York Times* revealed that a 2.2 million dollar settlement had been reached in the New Jersey Turnpike tragedy in which ten people lost their lives, almost 40 were injured, many of them seriously, and numerous vehicles were destroyed. When this paltry settlement is contrasted with an $800,000 award against a surgeon for a single misplaced belly button, and a recent 7 million dollar award for an anesthetic death during a tonsillectomy, it becomes quite clear that this is not paranoia, but that the members of our profession are indeed the victims of a legal system which discriminates in the value it places upon life and upon suffering, based upon the occupation of the defendant.

We are not paranoid—they *are* out to get us!

(signed) Robert A. Goldstone, M.D.

LETTERS FOR THE INFORMATION OF OUR READERS

To: The Board of Trustees

June 12, 1980

Dear Friends:

To be recognized by one's colleagues (especially while still alive!) as having done something worthwhile is indeed a singular honor. It is also sometimes difficult to know if one's efforts are appropriate and productive.

Being Chairman of the Board, and being tolerated for so long, is an honor that I will always cherish—but then, with the dedication and industry of the various Boards with whom I worked, it was a pleasure as well. Unless one is actually on the Board, he can never be aware of the pressures and tugs under which the Board must function. The Medical Society has been well served, and I have no doubts regarding future Boards.

Your kind expression of appreciation was indeed touching, and for it I thank you most sincerely. I will miss the Board and all you wonderful people who make it go, but please know I stand ready to be of assistance whenever needed.

Thank you ever so much.

(signed) James S. Todd, M.D.

To: Secretary, MSNJ

July 1, 1980

Dear Dr. Bernstein:

Thank you very much for your letters on behalf of the Medical Society of New Jersey. I appreciate your letting me know your views.

I think it is reasonably clear that any comprehensive program of national health insurance is still well in the future for the United States, and there should be wide discussion and careful investigation before a plan is adopted. I feel that we should make maximum use of existing health programs, to keep the cost down and the bureaucracy to a minimum. I share your concern that we should provide catastrophic health insurance—in fact, I believe that this should be our first priority.

As for HMO's—I have been greatly encouraged by the progress and success that has been achieved through these organizations. Health costs, especially hospital costs, are too high and rising too quickly, and I do not think we should discourage an approach which has maintained quality care and helped keep prices down.

Again, many thanks for writing.

With all good wishes,

(signed) Millicent Fenwick
Member of Congress

To: Secretary, MSNJ

July 3, 1980

Dear Dr. Bernstein:

We very much appreciate the concern of the medical society for the health and safety of populations living in the vicinity of hazardous waste dumps; we too share that concern and are engaged in an active campaign to eliminate existing sites and to prevent the formation of new ones.

We have currently estimated the existence of over 240 dump sites in New Jersey. Of these, some 80 were considered to comprise imminent danger and, due to our limited resources of money and manpower, we have targeted 23 for immediate cleanup. The site at Chemical Control was the biggest drum storage site, initially containing over 40,000 drums. Many were destroyed by the fire, and of the remaining drums we have cleaned out 25,000 and expect to be completely finished by the Fall. Cleanup for the twenty-three high priority sites should also be finished by the Fall of this year.

Over ten federal, state and local agencies were involved in responding to the Chemical Control fire. For this reason, a single source, the federal EPA, served as the central clearing house for all scientific information and data. EPA is about to release a report containing all the data taken at Chemical Control with annotations designating their significance. A copy of this report will be forwarded to you upon its release.

In order to provide the most immediate and informed health services, the agencies involved agreed that all health effects referrals should be addressed to local health authorities. In this case, all specific requests should be made to John Surmay, Director of the City of Elizabeth Department of Health.

(signed) Brendan Byrne
Governor of New Jersey

CME

The 43rd Annual Meeting of the Eastern Section of the American Thoracic Society will be held this year in Wilmington, Delaware.

Headquarters for the two-day scientific program will be the Hotel DuPont. Dates are Friday, September 26 and Saturday, September 27, 1980.

The Delaware Lung Association wishes to extend a cordial invitation to all interested physicians and medical students to attend this meeting. Registration fee is ten dollars for society non-members; no fee for students, residents, fellows.

For additional information and reservations, please contact the Delaware Lung Association in Wilmington at (302) 655-7258.

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Course Faculty:
Dr. R. Harwick (Temple University Hospital)
Dr. A. S. Miller (Temple University Dental School)
Dr. Sylvan Shane (John Hopkins School of Medicine)

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OPHTHALMOLOGY FOR THE FAMILY MEDICINE/ GENERAL PRACTICE PHYSICIAN

Wills Eye Hospital

TOPICS TO INCLUDE:

PRACTICAL ANATOMY AND PHYSIOLOGY
CORNEAL FOREIGN BODIES, ABRASIONS, CHEMICAL BURNS
CONTUSIVE AND PENETRATING INJURIES
MANAGEMENT OF THE RED EYE
GLAUCOMA FOR THE NON-OPHTHALMOLOGIST
STEROIDS AND OCULAR DISEASE
OCULAR COMPLICATIONS IN SYSTEMIC DRUG THERAPY
RECENT ADVANCES IN CATARACT TREATMENT

PLACE: WILLS EYE HOSPITAL
9th & Walnut Streets
Philadelphia, Pennsylvania
MAIN AUDITORIUM

TIME: SEPTEMBER 24, 1980
10:00 A.M. to 3:00 P.M.

FEE: NO CHARGE

CME CREDITS: M.D. and D.O.

FOR FURTHER INFORMATION AND REGISTRATION CONTACT:

DEPARTMENT OF CONTINUING MEDICAL EDUCATION
WILLS EYE HOSPITAL

Ms. Lucia M. Manes
(215) 928-3258

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Sept.

9 **Anesthesia for Thoracic Surgery**
7:30 p.m.—Helene Fuld Medical Center, Trenton
(Helene Fuld Medical Center and AMNJ)

Oct.

14 **Anesthesia for the Patient with Ischemic Heart Disease and a Recent MI**
7:30 p.m.—Helene Fuld Medical Center, Trenton
(Helene Fuld Medical Center and AMNJ)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Sept.

9 **Antibiotics**
11 a.m.—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hopsital and AMNJ)

9 **Respiratory Arrest**
8-9:30 p.m.—Shore Memorial Hospital, Somers Point
(Shore Memorial Hospital and AMNJ)

13 **Post Myocardial Infarction Cardiac Arrhythmias**

27 **Blood Gas Interpretations**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

15 **Special Bacterial and Serological Testing**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

16 **Rationale/Indications for Mini-Heparin**
12 noon—St. Mary's Hospital, Orange
(St. Mary's Hospital and AMNJ)

17 **Modern Approach to Patient Care**
1-5 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital and AMNJ)

17 **Proper Use of Prophylactic Antibiotics**
11:30 a.m.—Rahway Hospital
(Rahway Hospital and AMNJ)

18 **Update on Thrombolytic Therapy**
2-3 p.m.—Deborah Heart and Lung Center, Browns Mills
(Deborah Heart and Lung Center)

19 **Gastroenterology—Colitis**
12 noon—Freehold Area Hospital
(Freehold Area Hospital and AMNJ)

23 **Coronary Artery Disease**
11 a.m.—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

23 **New Jersey Blood Club**
7:30-9 p.m.—Coachman Inn, Cranford
(New Jersey Blood Club and AMNJ)

24 **Recent Advances in Internal Medicine and Therapeutics**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(Middlesex General Hospital and AMNJ)

25 **Immunology '81**
4-6 p.m.—Institute for Medical Research Copewood St., Camden
(Institute for Medical Research and AMNJ)

30 **Proper Use of Antibiotics**
2 p.m.—Ancora Psychiatric Hospital
(Ancora Psychiatric Hospital and AMNJ)

Oct.

1 **Recent Advances in Internal Medicine and**
8 **Therapeutics**
15 9-11 a.m.—Roosevelt Hospital, Menlo
22 Park
29 *(Middlesex General Hospital and AMNJ)*

2 **Immunology '81**
9 4-6 p.m.—Institute for Medical Research,
16 Copewood St., Camden
23 *(Institute for Medical Research and*
30 *AMNJ)*

8 **Alcoholic Cirrhosis and Hepatic Encephalopathy**
2 p.m.—John E. Runnells Hospital, Berkeley Heights
(John E. Runnells Hospital and AMNJ)

11 **Controversies in Nutritional Support: 1980**
8:30 a.m.-1 p.m.—Sheraton-Newark International Airport Hotel
(Newark Beth Israel Medical Center, NJ Medical School, McGaw Laboratories, USV Labs and AMNJ)

14 **What's New?**
8-9:30 p.m.—Shore Memorial Hospital Somers Point
(Eli Lilly and Company, Shore Memorial Hospital and AMNJ)

14 **Atherosclerosis, Allergy and Arachidonic Acid**
1:30-5:30 p.m.—Drew University Campus, Madison
(Drew University, Ciba-Geigy Pharmaceutical Division and AMNJ)

15 **Osteoporosis**
10:30 a.m.-12 noon—Jewish Hospital, Jersey City
(Jewish Hospital and AMNJ)

16 **2nd Echocardiography**
2-3 p.m.—Deborah Heart and Lung Center, Browns Mills
(Deborah Heart and Lung Center)

21 **Medical Problems Associated with Jogging**
Noon—St. Mary's Hospital, Orange
(St. Mary's Hospital and AMNJ)

21 **Coronary Artery Disease**
2 p.m.—Ancora Psychiatric Hospital
(Ancora Psychiatric Hospital and AMNJ)

25 **Diagnosis and Treatment of Skin Tumors**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

29 **Latest Treatment for the New and Old Sexually Transmitted Diseases**
9 a.m.-4 p.m.—St. Barnabas Medical Center, Livingston
(Essex County Medical Society, NJ Department of Health, St. Barnabas Medical Center and AMNJ)

NEUROLOGY/PSYCHIATRY

Sept.

4 **Lithium—Other Uses and Cautions**

9 **Psychodynamics in Prescribing**

18 **Patient Education—Medication and Self-Medication**

25 **Adverse Cardiac Reactions to Psychotropics**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

10 **Suicide**
8-10 p.m.—391 White Oak Ridge Road, Short Hills
(NJ Medical Women's Association Journal Club and AMNJ)

10 **DSM-III**

17 **Multiple Systems Therapy**

24 **Dependency in Psychotherapy: Transference and Countertransference Issues**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

16 **Psychological Aspects of Back Pain**
12 noon-1:30 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital and AMNJ)

17 **Geriatric Psychopharmacology: Treatment of Depressed, Elderly Patients**
1:30 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

24 **Physical Complaints without Organic Pathology**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

Oct.

1 **Eating and Weight Disorders**
9:30 a.m.-4:15 p.m.—Carrier

Foundation, Belle Mead
(Carrier Foundation and AMNJ)

4 **Prevention of Mental Illness in Children**
8:45 a.m.-4:30 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital, NJ Council of Adolescent Psychiatry and AMNJ)

7 **Psychotherapy of Schizophrenia**
11 a.m.—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

8 **Stress in the Family of the Mentally Ill Patient**

15 **Issues in Weight Control: Bulemia Nervosa**

22 **Theories of Group Psychotherapy**

29 **Sleep Disorders**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

8 **The Widening Scope of Psychoanalysis**
8:30-10:30 p.m.—Guido's Restaurant, Hackensack
(NJ Psychiatric Society and AMNJ)

9 **Lithium-Induced Diabetes Insipidus and Diuretics as Treatment**

16 **Facilitating Group Process Through Art Therapy**

22 **The GI Tract and Psychiatry**

30 **Lithium Update and Alternatives to Lithium**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

11 **Problems of Adopted Children**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

15 **Professional Stress "Burn Out"**
1:30 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

18 **Psychological Components of Learning Disabilities**
9 a.m.-5 p.m.—Rutgers Medical School, Piscataway
(Perceptions, NJ Academy of Pediatrics and AMNJ)

21 **Drug Addiction**
11 a.m.—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

22 **Updating Psychophysiologic Disorders**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

22 **Gastrointestinal Illness and Emotions**
4-6 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

RADIOLOGY

Sept.

4 **Ultrasonography of the Breast**
7:30-9:30 p.m.—St. Barnabas Medical Center, Livingston
(St. Barnabas Medical Center and AMNJ)

17 **Dinner Meeting**
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section; AMNJ)

18 **Topic to be Announced**
8 p.m.—Hospital Center at Orange
(Radiological Society of NJ and AMNJ)

Oct.

9 **Topic to be Announced**
7:30-9:30 p.m.—VA Medical Center, Lyons
(NJ Institute of Ultrasound in Medicine and AMNJ)

16 **Bone Diseases**
8 p.m.—Hospital Center at Orange
(Radiological Society of NJ and AMNJ)

OBSTETRICS/GYNECOLOGY

Oct.

23-26 **Sixth Annual Ignatz Semmelweis Obstetrical Seminar**
Cherry Hill Inn, Cherry Hill
(CMDNJ and AMNJ)

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastic, and Vascular Surgery.)

Sept.

18 **Management of Dissecting Aneurysms**
8-9 p.m.—Burlington County Memorial Hospital, Mt. Holly
(Burlington County Medical Society and AMNJ)

18 **Spinal Cord Injury Service Quarterly Meetings**
1-2:30 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

23 **Regional Flaps: Use in Reconstructive Head and Neck Surgery**
8-10 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

Oct.

28 **Management of Pressure Sores**
8-10 p.m.—Englewood Hospital, Englewood
(Englewood Hospital and AMNJ)

MISCELLANEOUS

Oct.

17 **Malpractice**
12 noon—Freehold Area Hospital
(Freehold Area Hospital and AMNJ)

OBITUARIES

Dr. Malcolm M. Dunham

We just have learned that one of Middlesex County's senior members, Malcolm M. Dunham, M.D., died on May 12. Born in 1909, Dr. Dunham was graduated from Jefferson Medical College, class of 1935, and pursued a career in general medicine in Woodbridge, his home community. He had been affiliated with Perth Amboy General Hospital. Dr. Dunham served three and one-half years with the medical department of the United States Navy during World War II.

Dr. James L. Hollywood

A well-known Jersey City physician, James L. Hollywood, M.D., died on June 15 at his home after a brief illness. A native of Pennsylvania, born in 1904, Dr. Hollywood was graduated from Jefferson Medical College, class of 1929, and practiced family medicine for almost fifty years. He had been affiliated with Greenville and St. Francis Hospitals in Jersey City and with the Jersey City Medical Center. During World War II he served with the medical department of the AUS. Dr. Hollywood was a recipient of MSNJ's Golden Merit Award in 1979, honoring his fifty years as a physician.

Dr. Phoebe Hudson

An affiliate member of the Bergen County Medical Society, Phoebe Hudson, M.D., who had practiced in Hackensack until 1977 when she moved to Arizona, died on April 2 after a prolonged illness. A native of Wilmington, Ohio, Dr. Hudson was graduated from the medical school of Western Reserve University in 1948 and pursued graduate training in pediatrics, becoming board certified in that specialty. She was a Fellow of the American Academy of Pediatrics and had been affiliated with the Hackensack Hospital when she practiced in New Jersey.

Dr. Joseph L. Kostecki

We have received word of the sudden death on April 25, following a myocardial infarction, of Joseph L. Kostecki, M.D., a member of our Passaic County component. A native of New York, born in 1905, Dr. Kostecki was graduated from New York University School of Medicine in 1932 and pursued graduate training in plastic surgery, becoming board certified in that specialty. He was a Fellow of the American College of Surgeons. Now retired, Dr. Kostecki practiced in New York until coming to New Jersey in 1972. He was assistant clinical professor at Downstate Medical College in Brooklyn, and had been affiliated with King's County Medical Center and Catholic Medical Center in New York where he was chief of the department of plastic surgery.

Dr. J. Earl Miles

At the grand age of 86, J. Earl Miles, M.D., died at his home on June 11. A native of Kentucky, Dr. Miles earned his medical degree from the University of Louisville in 1919 and practiced surgery in Brooklyn and Byram Township (New Jersey) for fifty years before retiring in 1970. Dr. Miles was a Fellow of the American College of Surgeons and had been affiliated with St. Clare's Hospital in Denville. In 1969 Dr. Miles received MSNJ's Golden Merit Award in recognition of his fifty years of service as a physician.

Dr. Frank A. Nonziato

A well-known Mercer County physician, Frank A. Nonziato, M.D., died at his home on June 15. A graduate of Georgetown University Medical School, class of 1932, Dr. Nonziato practiced family medicine with special interest in obstetrics, and had been affiliated with the St. Francis Medical Center in Trenton. Dr. Nonziato was 74 years old at the time of his death.

Dr. Sripada B. Quencro

At the untimely age of 58, Sripada B. Quencro, M.D., died suddenly at his home on April 2, following a myocardial infarction. A native of India, Dr. Quencro was graduated from Goa Medical School in Goa, India in 1948 and practiced there until emigrating to the United States in 1959 for graduate work in pathology, becoming board certified in that specialty. He established a general practice in the Bronx until 1972 when he came to New Jersey as assistant pathologist at Paterson General Hospital. Dr. Quencro was a member of the American Society of Clinical Pathologists.

BOOK REVIEWS

Handbook of Poisoning, 10th Edition.

Robert R. Dreisbach, M.D. Los Altos, CA, Lange, 1980. Pp. 578. ($9)

This very usable little book (4-1/4 x 6-7/8 x 1-1/16 in.) covers the entire field of clinically significant poisons, organizing them among agricultural, industrial, household, medicinal, animal, and plant hazards. Agents are included in more than one category when appropriate. The 69-page index lists potentially toxic substances by generic as well as by brand names, facilitating the location of a particular agent within the text.

The new sections in this edition on pharmacokinetics and drug interactions are extremely brief, but this is not a deficiency in a handy volume that gives excellent coverage to the subjects of prevention, diagnosis, evaluation, management, and the doctor's legal and medical responsibility in poisoning. The continuous increase in our environment of substances that are found to be toxic mandates the updating of our libraries with books such as this.

Hyman W. Fisher, M.D.

The Diabetic Gourmet, rev. ed. Angela Bowen, M.D. New York, Harper and Row, 1980. Pp. 193. ($10.95)

This is another of the excellent books that can make the life of the diabetic person more satisfying. It is a collection of recipes of the author and of her friends and relatives, most of them quite simple. They are presented in a breezy, folksy style, with such little hints as "heating or freezing changes the taste of saccharin to everything but sweet," as well as "don't discard the pot liquor, it contains the potassium from the food." There is even a trout dish to be cooked in the dishwasher but no reason for this is given.

The recipes are detailed in a manner easy to follow, and are surprisingly uncomplicated. A special effort has been made to make the dishes appealing not only to taste but to the eye as well. Calories per serving are listed and there is a breakdown of the protein, fat, and carbohydrate per serving so that the patient easily can fit them into exchange diets. A few of the recipes are not low fat, but can be made so by substitution.

This is a book to be recommended to any diabetic who enjoys good food and rebels against the tasteless monotony of a restricted diet.

Samuel E. Einhorn, M.D.

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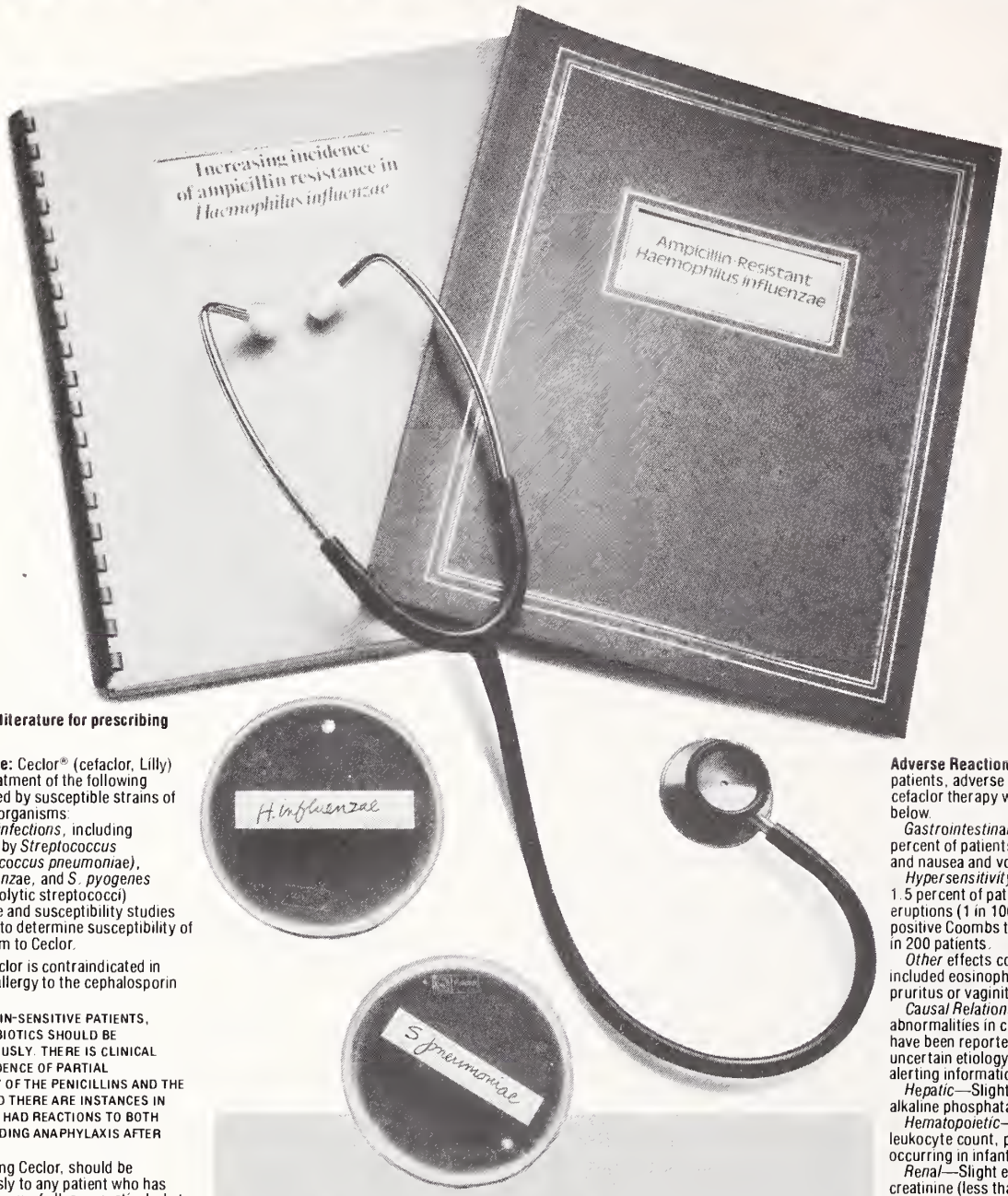
An added complication... in the treatment of bacterial bronchitis*



Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:
Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)
Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

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Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

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Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.
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Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.
Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).
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Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).
Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.
Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).
Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).
Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.
Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.
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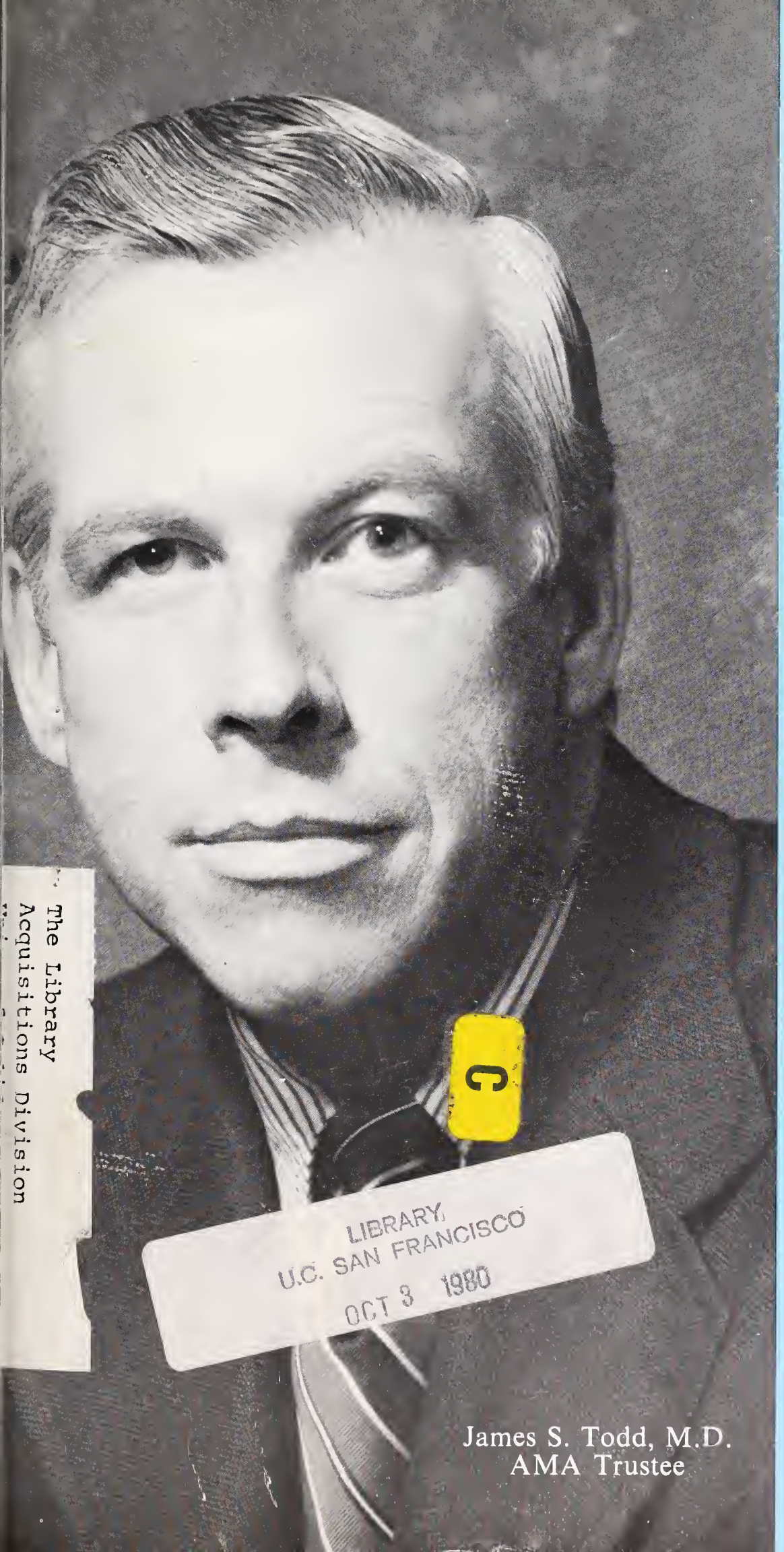

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Accident Facts. Chicago, Illinois, National Safety Council, 1974.

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Featuring: A Product Liability Case

BENDECTIN®—HARMLESS?

A federal court judge in Florida has set aside the jury verdict and ordered a new trial in the first litigated products' liability case involving the drug Bendectin®. The ruling, issued May 12, 1980, resulted from challenges to a March 21, 1980, jury award of $20,000 to the parents of a boy born with multiple birth defects in *Mekdeci v. Merrell National Laboratories, Inc.*, 77-255.

The boy had a missing pectoralis muscle, depressed sternum, shortened right forearm, two missing fingers on the right hand and webbing between the thumb and first finger. His mother, Elizabeth Mekdeci, had charged in a $10 million suit that the drug, manufactured by Richardson-Merrell, Inc., had caused the deformities. Mrs. Mekdeci took Bendectin® to alleviate nausea in the first trimester of her pregnancy.

The judge set aside the jury's monetary award to the parents calling it a "compromise" verdict which was contradictory to the evidence and to the law. The judge had instructed the jury not to make a monetary award unless it found that Bendectin® caused the child's defects.The jury did not award damages to the child. Rather, it ordered the manufacturer to pay $20,000 for the boy's claimed medical expenses.

Both the plaintiff and the defendant filed motions challenging the verdict. The judge denied those motions and instead ordered a new trial.

The jury verdict had not established a causal link between the drug and the birth defects. Ruling that it was his duty to overturn the verdict, the judge said, "if the jury felt that the drug was the proximate cause of the child's malformation or proximately contributed thereto, there must have been an award of damages to the child."

Before the judge set aside the jury's decision, Dr. Arthur Cohen, a Miami physician/attorney who was retained as co-counsel for the plaintiffs, said the verdict meant that physicians should stop prescribing Bendectin® for use in pregnancy.

The attorneys for Richardson-Merrell, however, saw the jury's failure to award damages to the child as a vindication of Bendectin®. They had argued at trial that the child's constellation of defects was "Poland's syndrome" first described in England in 1841.

Should physicians stop prescribing Bendectin® to pregnant patients? Although Bendectin® has been approved specifically for use in pregnancy, the FDA has collected about 90 cases reported by physicians in which a woman who has taken the drug has given birth to a malformed child. But because physicians were not asked to report birth defects in connection with Bendectin® use, the number of reported cases may be well below the actual occurrence.

Among the issues debated at the trial was the validity of animal studies of Bendectin® teratogenicity conducted by Richardson-Merrell. One study showed a level of birth defects below that of the control group. Another study was conducted on an unusual species of rabbit whose natural teratogenesis has not been established clearly. The researcher who conducted that study left the company without publishing his results. Other company scientists concluded that the defects noted by that researcher occurred at no more than the normal rate for that species of rabbit.

Critics of the manufacturer's research, including a past researcher from Richardson-Merrell, have admitted that the early animal studies used too few test animals and such low doses of Bendectin® that low-grade teratogens could have escaped detection.

A recent human study conducted by the Center for Disease Control also has been criticized. That study, based on data collected since 1970, employed the case control study method, in which mothers who have given birth to defective children are interviewed regarding their drug history during pregnancy. The study has been challenged because of problems in mother-recall bias, lack of adequate controls as to the ingestion of drugs other than Bendectin® during pregnancy and the CDC's failure to pursue physician-treatment records.

None of the human or animal studies conducted to date has been conclusive. The FDA has found no significant statistical relationship between Bendectin® and birth defects. However, it has recommended that primate studies be conducted to settle the question definitively. Because Bendectin® has been approved for sale since 1956, it is unlikely that the FDA will withdraw the drug from the market unless a strong case against use of the drug is proved.

Meanwhile, Bendectin® will receive a new trial in the courts. To be successful, the plaintiff attorneys must convince the jury that there is a reasonable medical probability that Bendectin® was a factor in the development of the child's birth defects.

Therefore, based on inconclusive data, the treating physician must decide for himself whether or not to prescribe Bendectin® or other drugs to pregnant patients. No drug is free of possible risk of harm to either patient or fetus. Thus, the same advice which physicians give for patient drug ingestions during pregnancy applies to Bendectin.® The most sound general rule for physicians is that no drugs should be prescribed during pregnancy unless absolutely necessary. All physicians await the outcome of the next Bendectin® trial with great anticipation. J.E.G.

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*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

DID YOU KNOW

. . . St. Paul Fire and Marine Insurance Company spends 35¢ of every dollar on administrative costs, according to Mr. Thomas H. Swain, the company's Executive Vice-President. (Medical Inter-Insurance Exchange of New Jersey spends 6¢ of every dollar on administrative costs.)

. . . Patients sue because they are angry and want to strike back and because they resent unexpected outcomes. "Surprise" results of a procedure are responsible for better than 50 percent of the claims. Physicians should be certain to inform patients of possible risks and complications, according to Robert Buttain, M.D., President, Medical Liability Consultants Program, Inc., Denver, Colorado.

. . . A big reason why patients improperly medicate themselves is that the common teaspoon most patients use to measure medication holds anywhere from half to twice the proper amount, a University of Michigan study shows. The study cautions physicians to be alert for complications that can arise when a dosage is only ten percent off. (*Medical Economics,* January 7, 1980)

. . . According to St. Paul's claims analysis reports from October 1973 to March 1980, the following top three allegations account for 86 percent of all anesthesia-related claims: cardiac arrest—32 percent, adverse reaction—29 percent, and teeth damage—25 percent. (*Malpractice Digest,* June 1980)

. . . New York's Medical Liability Mutual Insurance Company, the third largest malpractice insurance company and the largest run by physicians, will ask the state to okay a 43 percent premium increase. High premium surgical specialists will pay as much as $28,653 and ob/gyn charges will be as high as $23,835. (*Medical World News,* July 7, 1980)

NJ JURY AWARDS $1 MILLION

A superior court jury awarded $1,378,000 to a woman who sued for negligence that resulted in her husband's death after a motorcycle accident four years ago. The verdict is the largest medical malpractice judgment in New Jersey history.

Named in the suit were two physicians, one of whom agreed to an out-of-court settlement, and two nurses. Testimony revealed that the patient was admitted to the emergency room complaining of back and body pain. The physician admitted him to a regular ward after taking a series of x-rays that showed a fractured pelvis. The physician testified that he failed to record the fracture and did not notify anyone of the injury. A consulting surgeon, who also examined the patient, decided to leave the patient in the ward.

The patient's wife, a former licensed practical nurse, questioned why her husband was not in the intensive care unit and why he was not receiving oxygen, since he was having difficulty in breathing. Hospital authorities felt neither provision was necessary.

The jury determined that two nurses were negligent in monitoring the patient's progress during the night. At about 1:15 a.m. the patient's condition worsened and he was rushed to the intensive care unit where he suffered a cardiac arrest and died.

An autopsy revealed that the patient suffered a shattered pelvis, internal bleeding and nine fractured ribs that complicated his breathing and eventually lead to his death.

The widow and mother of four received $1,150,000, plus interest, in damages for the family's loss of support, guidance and care from her husband. The estate also received $9,900, plus interest, for funeral expenses and the patient's pain and suffering while in the hospital.

Four out of five N.J. doctors participate!

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EDITORIALS

Congratulations, Dr. Todd

Our immediate past-chairman of the Board of Trustees, James S. Todd, M.D., whose devotion to this Society and overall leadership in Medicine were acknowledged in a resolution presented to and unanimously adopted by our House of Delegates in May, has been recognized nationally by election to membership on the Board of Trustees of the American Medical Association during the July meeting of the AMA's House of Delegates.

Not since Dr. David B. Allman (Atlantic County) was President of the AMA in 1957-1958 has New Jersey been represented on the governing body of our parent organization. New Jersey is honored by the selection of Jim Todd.

We congratulate Dr. Todd who singularly deserves this national recognition and wish him a successful and rewarding experience. A.K.

Impaired Physicians

The problem of the impaired physician is gaining nationwide attention, both within and without the medical profession. The AMA, for example, takes the subject so seriously that it is planning its Fourth National Conference on Impaired Physicians this fall in Baltimore. One reason: some state government agencies are not satisfied with organized medicine's approach to the problem and are threatening to step into the issue in a controlling way. For example, Governor Brown of California has formed a Board of Medical Quality Assurance to deal with such problems in that state. This is bad news for California Medicine.

Whether a physician is impaired from substance abuse (drugs, alcohol), physical disease, an organic mental syndrome or a psychiatric disorder, the potential harm to himself, his family, his patients, his colleagues and his profession is incalculably high. A major feature of such impairment is the inability or unwillingness of the impaired physician to recognize and to accept his problem and its appropriate, though painful, solutions. It is not easy to put a dollar value on the costs of these problems—let alone document those which fail to come to light. In one instance of which I am aware, a general practitioner has been an alcohol abuser over many years and obviously developed cerebral impairment, with resultant poor judgment and poor medical practice. A law suit by an irate patient and family resulted. The insurance carrier investigated and made a substantial out-of-court settlement because of the indefensibility of the claim. The physician still is practicing in the same fashion so one can predict that more such indefensible suits are likely.

Education is not the answer. Punishment is nonproductive. Negotiation is closer to a positive approach, but the subject is too sensitive, too complex and too personal to yield to simplistic solutions. We tend to avoid rather than deal with such problems when they are staring us in the face.

There *is* an immediate technique which can be an initial step. Prevention is obviously the best treatment but early detection and therapeutic intervention, when rehabilitation still is possible, is a close second choice. But prevention must come in the future. Meantime, one can learn something from studies dealing with smoking onset and cessation. It has been shown that techniques of behavior modification, aversive conditioning and fear-producing information has had little effect on adult smokers. Social psychologists now have turned to children in the 10 to 12-year age group to try to prevent smoking onset. But even here it is quite clear that education and information per se will not convince such children not to smoke. Education and information will not influence an impaired physician either.

The place to start with the problem of the impaired physician is the hospital, and the group which must act is the medical staff. The president of every New Jersey hospital medical staff should appoint a permanent committee on impaired physicians today. The constitution and bylaws committee of each hospital medical staff should develop a definitive technique for dealing with impaired physicians and seek without delay to gain the accord of the entire medical staff. Each member of the staff should be required to sign a

statement of agreement to cooperate with the hospital staff committee should his ability to function appropriately be called into question. Physicians who are active in hospitals observe each other regularly at all times of the day and night. Formally, through utilization review committees, tissue committees and the like, we evaluate each other's professional activities. At lunch and in conferences, educational sessions and at committee and staff meetings, we observe each other. We physicians are together socially and professionally. We consult with each other on a daily basis. It should not be difficult to recognize a colleague with a problem. To date, however, it has been very difficult to deal with such colleagues.

If the hospital committee cannot solve the problem, it could be referred to the Medical Society of New Jersey Committee on Impaired Physicians for study and advice. Failure of any physician on the staff to sign such an agreement could be considered a reason to deny hospital privileges. New applicants for staff privileges should sign before appointment becomes effective. Failure to cooperate with the committee should result in suspension of hospital privileges to protect the patients, the hospital and the involved physician himself.

We recognize that this system will do nothing for the physician who practices outside of organized medicine. If he has a license to practice, but does not belong to any medical society or hospital, a physician then becomes the province of the New Jersey State Board of Medical Examiners. The problem then is the Board's problem unless such a physician seeks help from his colleagues.

Any corrective system dealing with such a serious problem needs teeth. It is time for the medical profession to take a responsible approach toward those physicians who are impaired by addiction to alcohol or drugs, by organic mental syndrome, disabling physical disease or psychiatric disorders. We cannot sweep the problem under the rug, turn our backs on it or hope it will go away. We must act first before others step in. We owe it to our profession and we owe it to our impaired physician colleagues.

A.K.

New Jersey Society for the History of Medicine

History is a verbal or written link with our colleagues of another era, which permits us to vicariously experience and share some aspects of our lives. This is especially pleasurable in the fraternity of medicine, whose members have remarkably similar lives, by the nature of the profession, though they be separated by decades or even centuries.

An example can be found in the July 28, 1860 issue of *The Medical and Surgical Reporter: A Weekly Journal* edited by S.W. Butler, M.D. and R.J. Levis, M.D. A letter to the editors, which was signed by "M.D. Abroad," reads as follows:

"Gentlemen:—As I am now in London I shall be enabled to send you a description of some of the hospitals. Of these there are two different classes, one of which were in old times monasteries, the lands of which have become, in the progress of time, of immense value; even so much as to produce to some of them £40 or £50,000 a year. Such are St. Bartholomew's and some others. The other class consists of those which have been formed in more recent times, and which are in most respects similar to those of our own country.

"On last Wednesday I visited Guy's Hospital, which is the one of which I had heard most, and which, I think, is most familiar to Americans. The oldest part of the present building is 150 years old. Other portions have been added from time to time, and at present 560 patients can be accommodated at once. They do not, however, keep all the beds full; for, as a general rule, not more than 500 patients are in the hospital. The remaining beds are purposely kept vacant, so as to be ready in case of any sudden calamity, such as a railroad accident, causing a great influx at once.

"At the time of my visit a chill had just been thrown over those connected with Guy's by the sudden death of Mr. Addison, the celebrated discoverer of the connection between diseases of the supra-renal capsules and a peculiar bronzing of the skin; and who has likewise distinguished himself by his investigation in diseases of the skin; one disease of which (Addison's keloid) has received its name from him, he having first called attention to it. Mr. Addison had passed his 70th year. The circumstances of his death were peculiarly distressing. For some time past he had been observed to have something peculiar in his manner, but no fear had been entertained in consequence of that, of any danger to himself or others. A short time before my visit he threw himself from a height, and was instantly killed, and when I was at the hospital, he had not yet been buried. A terrible end indeed, and most unexpected.

"The wards of Guy's it is hardly necessary for me to describe, as they are very similar to those which I saw in the Royal Infirmary at Liverpool, with the single exception of being considerably longer. They are much narrower than our wards at home, and the ceilings are much lower.

"An object of great interest connected with Guy's Hospital is the museum, which is highly interesting and well worth inspection. It is contained in three large rooms, each with a double gallery running around the walls. One of these rooms contains the Museum of Comparative Anatomy, in which are to be found preparations representing the progress of the formation of the chick in the egg; also a large number of skeletons of various animals. I was more interested, however, in the Anatomical and Pathological rooms—and especially in the models by Mr. Towne, the celebrated modeller in wax. The sight of them produced on my mind quite a home feeling, as a very large proportion of them were exact copies of those representing skin diseases in the museum of Dr. Wood in the University of Pennsylvania. Perhaps I ought rather to call those at Guy's the originals, and those at home the copies. The similarity however is complete. I do not believe that any difference could be discovered by the maker himself. In this department of the museum there is a marble bust of Mr. Addison, made by Mr. Towne, which was

admirably done. On the slightest inspection it could be seen that the likeness must be a good one. I have no doubt that if Mr. Towne had turned his talents to work as a sculptor, he would have become distinguished in that line. He had just completed a wax model of a boy afflicted with disease of the supra-renal capsules, and who had died of that disease. He had been brought to the hospital with his skin bronzed, and Dr. Addison had prophecied his death, and that the supra-renal capsules would be found diseased. He did this before many doubting physicians in London, and the conclusion justified his prediction.

"I was very much pleased with the arrangement of the museum, and also with the catalogue, which related very particularly all which was interesting concerning the case treated of. If I were to describe the preparation, it would be difficult to know where to begin. I noticed one preparation, of an enormous size, representing the osseous base of a fungoid disease of the femur.

"Another, in a conspicuous position, was the scalp of a negro with all the wool, a thing which would hardly be considered necessary to preserve with such care in the United States. On one side of it was the scalp of a native of the Ladrone Island, and on the other that of an Omyhee.

"There were several students in the museum at the time I was there, engaged in studying the preparations; many of which they were allowed to take down for the purpose of study. Posted up in every room I saw printed in large capitals, 'Silence is indispensable in a place devoted to study.'

"Guy's Hospital is situated on the south side of the Thames, and near London Bridge. St. Thomas' Hospital is close by. In entering you walk at once without being obliged to knock or ring, into the courtyard, in which is a statue, I believe of the founder of the hospital, and then up some steps into a covered walk or arcade, with the rooms of the porter, steward, and so on, on each side; and also staircases leading to the upper wards. Having passed through the whole length of this arcade you come again into the open air, and find yourself with the museum on the right, and some buildings on your left, one of which is the office of Mr. Towne. I was very much pleased at seeing grass for the patients to walk on, although not in anything like the same abundance as at the Pennsylvania Hospital.

"I must not conclude without mentioning the anatomical models by Mr. Towne. There were models of different parts of the human frame done in wax. Those representing the nerves were especially admirably done. They were of the size of life, and it was really hard to persuade yourself that it was not a recent dissection at which you were looking.

"I shall take up the subject of Guy's Hospital again at a future period.

"In the meantime, I remain yours truly, 'M.D. Abroad' "

Having visited Guy's Hospital in London, and having enjoyed the opportunity of gazing at the remarkable art of Mr. Towne, your Editor can savor the experience of "M.D. Abroad" and relive a personal adventure through this delightful letter written 140 years ago.

Through the stimulus and efforts of Dr. Morris H. Saffron, a devoted medical historian, an ad hoc committee met on June 25, 1980 to sow the seeds which will grow into the New Jersey Society for the History of Medicine. This organization will follow the example of the American Association for the History of Medicine and will be open to physicians, scientists, health professionals, students, and others who are interested in the history of medicine.

The first formal meeting of the new society will be held on Wednesday, October 8, 1980 at the CMDNJ-Rutgers Medical School in Piscataway. Among the activities will be the presentation of several papers, a business meeting, and a pleasant lunch.

Members of the Medical Society of New Jersey and of the Academy of Medicine of New Jersey, and others with a feeling for the past as it relates to the present and the future, should attend this meeting and join the New Jersey Society for the History of Medicine.

A.K.

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Although over 80% of post-coronary patients can resume normal marital sexual activity, fear of anginal pain often results in "cardiac separation" between patients and their families.

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Reference 1 Hellerstein HK, Friedman EH Sexual activity and the postcoronary patient Arch Intern Med 125,987 1970

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JEM PAC New Jersey Medical Political Action Committee

JEMPAC REPORTORIAL*

QUALITIES OF GOOD CANDIDATES

Above all, candidates must be honest and have integrity. Their behavior must be legal, moral and ethical, and these qualities must be apparent to all who meet them.

There are physical attributes which are desirable, but not absolutely necessary. A pleasant, youthful appearance exuding good health and exhibiting an even temperament are desirable attributes. Candidates should have an ability to meet people and to speak well publicly. They should have administrative abilities and leadership qualities. In addition, candidates should have a good reputation among community leaders, a real desire to be a candidate and enough energy to devote a great deal of time toward campaigning, a knowledge of the district, a record of involvement in local organizations, a good reputation among their own party members and knowledge of national and international issues. Integrity is the only attribute which every candidate **must** have. They may not have **all** the desirable attributes; but they must have enough of them to make their campaign winnable.

INCUMBENT vs. CHALLENGER

If the candidate is an incumbent, he is more likely to be a winner than if he is challenging an incumbent. Incumbency offers the advantages of name recognition, franking privileges, telephone and travel allowances, a ready-made staff, rent-free offices, office equipment, first chance at funds from the party's congressional campaign committees, and a congressional voting record.

If the incumbent is a freshman, his advantages must be ranked considerably lower. The more years an incumbent has served gives him all the advantages of incumbency many times over. A freshman incumbent must be considered vulnerable to defeat.

However, if there are advantages in holding the office, there are also disadvantages. The disadvantages are the challenger's strong points. The challenger can mount a continuous campaign in the district, while the incumbent must stay in Washington. A challenger has no voting record in the Congress, so his opposition has no prior actions to attack. The incumbent's voting record may be a vulnerable one, so that the challenger may be able to attack it. In other words, the challenger has the advantage of running an offensive campaign, and may trap the incumbent into running a defensive campaign.

A district in which the incumbent won his last race by less than five percentage points is considered statistically marginal. Marginality is a plus factor for the challenger since it means he has a better chance of winning the district away from the incumbent.

An open race (a district in which the incumbent is not seeking reelection) is considered an "opportunity" race for either party. All the factors of incumbency are not present, and the candidates are placed on a more equal footing.

The ideal candidate then is one who is honest, has all the personal characteristics desirable in a good candidate and is an incumbent with two or more terms seniority in a non-marginal district. If your candidate fits this description, his "winnability" is rated very high. But he doesn't always win. How is defeat snatched from the jaws of victory?

In the next issue vulnerability will be discussed.

CANDIDATE EVALUATION COMMITTEE FORMED

Frank Y. Watson, M.D., Chairman of JEMPAC, has formulated a committee to make recommendations regarding monetary contributions to campaigns of New Jersey candidates for Congress. The committee will be chaired by Harold Colburn, M.D.; its members are Nathan Asbell, M.D., Karl Franzoni, M.D., Robert Rigolosi, M.D. and Mrs. Frank Romano. Mr. Vincent A. Maressa, Executive Director of MSNJ, and Mr. Joseph Katz, lobbyist for MSNJ, will serve as consultants to the committee.

JEMPAC MEMBERSHIP 7/80

County	1979 MSNJ	1979 JEMPAC	%	1980 MSNJ	1980 JEMPAC	%
Atlantic	218	3	1.4	195	2	1.0
Bergen	1064	55	5.1	1027	67	6.5
Burlington	241	20	8.3	245	15	6.1
Camden	529	28	5.3	521	44	8.4
Cape May	51	0	0	47	0	0
Cumberland	127	5	4.0	116	6	5.2
Essex	1564	48	3.1	1488	80	5.4
Gloucester	105	8	7.5	102	14	13.7
Hudson	495	9	1.8	440	12	2.7
Hunterdon	79	1	1.2	62	2	3.2
Mercer	555	26	4.5	497	27	5.4
Middlesex	534	12	2.2	545	19	3.5
Monmouth	524	22	4.1	509	22	4.3
Morris	484	20	4.1	463	27	5.8
Ocean	255	8	3.1	253	16	6.3
Passaic	662	24	3.7	655	32	4.9
Salem	40	5	13.0	40	3	7.5
Somerset	159	1	0.6	157	7	4.5
Sussex	74	2	2.7	73	6	8.2
Union	759	53	7.0	750	103	13.7
Warren	61	3	5.0	60	7	11.7
	8580	355	4.1	8245	511	6.2

MSNJ'S POSITION ON PROPOSED NJ LEGISLATION

Senate-1089—David Frieland, et al. (32nd District, part of Hudson)

To amend the law to permit the payment of costs and legal fees in professional liability suits when it is determined that such suits are frivolous, etc. **ACTIVE SUPPORT**

Senate Bill 1089 has been assigned to the Judiciary Committee:

William V. Musto, Chairman, John Skevin, Vice-Chairman, William J. Hamilton, Joseph A. Maressa, Carmen Orechio, Steven Perskie, John Russo, Walter N. Sheil, James S. Cafiero, John H. Dorsey, Thomas Gagliano, James P. Vreeland.

Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of the JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

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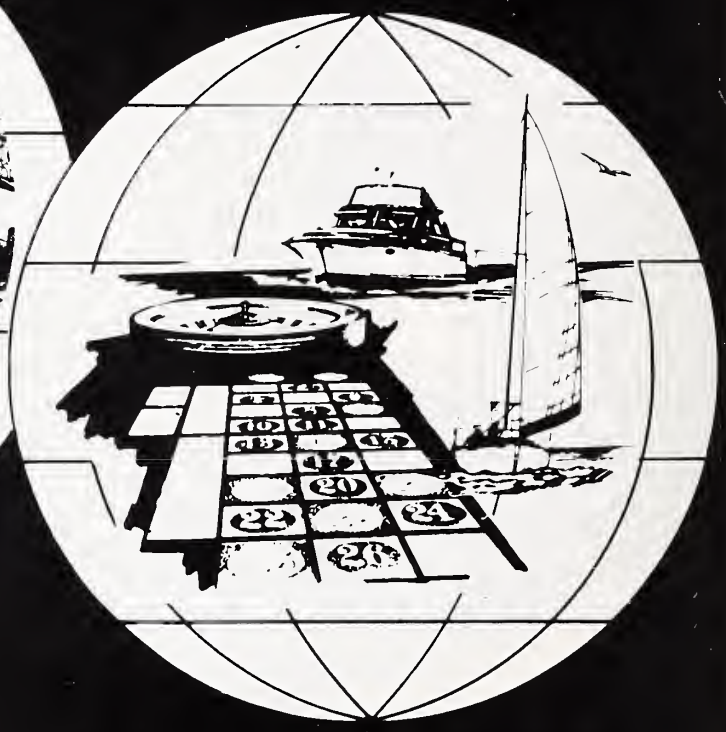

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Cerebral Concussion: An Area-Wide Survey of Clinical Experience with 467 Cases*

T. MAIO, M.D. and W. A. DWYER, JR., M.D., Paterson

A survey of 467 consecutively admitted cases of cerebral concussion is reported. One hundred and eighteen cases were reviewed prospectively; the remainder retrospectively. In the prospective group, nine cases with significant pathology not apparent at the time of admission were found. In the retrospective group, a limited treatment regimen and a rather disproportionate use of ancillary tests was noted. It appears that admission for this syndrome is justified, but better care and a shorter hospital stay would result if these patients were screened by a neurologist prior to the use of ancillary measures, apart from a skull x-ray series.

The patient presenting with a history of derangement of consciousness associated with a blow to the head represents a problem in management for the primary treating physician. Despite seeming triviality of injury, the possibility of a serious underlying intracranial problem must be considered. On this basis, many primary physicians and particularly those who are in hospital-based emergency practice have developed a policy that all patients presenting in the emergency room with such a history must be admitted for observation for a period of time, frequently 24 hours.

While this approach helps to reduce the likelihood that serious sequelae of head injury will be "missed," it does result in the hospitalization of a number of patients who have relatively minor or no neurological problems. In this era of cost consciousness, such a policy raises questions regarding the necessity of admissions, treatment rendered to such cases, and the length of time that is required for the patient to achieve maximal hospital benefit. Regrettably, there have been very few reports which address these issues.

In this paper the authors present the results of a study designed to determine the natural course and possible complications arising in patients admitted with the diagnosis of cerebral concussion and attempt to determine what diagnostic and treatment modalities were employed in such patients once they were admitted. The study has involved cases admitted to the seven acute care hospitals in the Passaic Valley PSRO area.

MATERIALS AND METHODS

The Passaic Valley PSRO area is a mix of inner-city and suburban municipalities. As such, it encounters trauma in all its manifestations.

In designing the study, the problems of the primary treating physician initially were considered. This physician is confronted with a patient whose history contains an element (unconscious period) which he did not observe, but which might represent the early phase of a serious neurosurgical problem. He is in no position, either by training or on clinical grounds, to judge the issue. Therefore, the first part of the study was a prospective study of patients with an *admitting* diagnosis of cerebral concussion alone. In all, 118 cases have been studied to determine what, if any, neurological sequelae followed the initial concussion.

For purposes of the study, the admitting diagnosis, substantiated by a recorded history of a "brief period of unconsciousness," has been considered a sufficient definition of cerebral concussion whether or not neurological changes or alterations of the state of consciousness have been present. This definition appears to correspond reasonably well with

*From the Passaic Valley PSRO and the Surgical Service, St. Joseph's Hospital and Medical Center, Paterson, N.J. The authors wish to acknowlege the work done in this survey by the staffs of the area hospitals and, in particular, by Dr. J. Kaplan, Dr. S. Knep and Dr. R. Rubin. Correspondence may be addressed to Dr. Dwyer at the Passaic Vally PSRO, 573 Valley Road, Wayne, New Jersey 07470.

"... clinical syndrome characterized by immediate and transient impairment of neural function such as alteration of consciousness, disturbance of vision, equilibrium, etc. due to mechanical forces."

Table 1
Morbidity and Mortality

	Mortality	Morbidity
Prospective Group (118)	0	8%
Retrospective Group* (334)	0	16%

*A mortality did exist in the original 350 cases, but was found to be improperly coded.

Table 2
List of Complications

Prospective Group (118)			Retrospective Group		
Subdural Hematoma	1	(0.9%)	Bleeding from nose or ears	4	(1.2%)
Basilar Skull Fracture	6	(11.4%)	Seizures	2	(0.6%)
Seizures	2	(1.8%)	Persistence of:		
Total	9	(7.6%)	Lethargy	17	(5%)
			Confusion	5	(1.4%)
			Nausea and/or vomiting	5	(1.4%)

the definition of concussion developed by the Congress of Neurological Surgeons[1]: "clinical syndrome characterized by immediate and transient impairment of neural function such as alteration of consciousness, disturbance of vision, equilibrium, etc. due to mechanical forces."

After completion of the first survey, a second retrospective study was constructed to determine how much diagnostic and treatment effort had been expended on the patient suffering only from concussion. This study involved a review of 350 cases with a *final* diagnosis of cerebral concussion, utilizing the Joint Commission on Accreditation of Hospitals' audit method.

Our audit criteria were developed by a team of area neurologists in conjunction with the Medical Care Evaluation Committee of Passaic Valley PSRO.

RESULTS

The prospective study reviewed 118 cases sequentially admitted to the area hospitals over a two-month period in 1976. As can be seen from Table 2, 7.6 percent of these cases were shown to have additional problems, not apparent at the time of admission. Six patients had basilar skull fracture but no other associated problems. Therefore, 2.5 percent can be considered to have serious neurological sequelae, one of which must be considered life-threatening (subdural hematoma). While this prospective study was not designed to determine the types and numbers of complications, the reviewers did comment that the frequency of symptomatology seemed low in the portion of this group without neurological sequelae.

Three hundred and fifty case records were reviewed in the retrospective study. These represented fifty consecutive patients from each of the area hospitals discharged in the year 1977. One of these case records was found to be miscoded (the patient actually was operated on for a subdural hematoma and subsequently died). Sixteen charts were found to lack justification in the record for the final diagnosis. Thus, 334 case records reviewed in detail using the Joint Commission on Accreditation of Hospitals' audit method met the audit criteria developed by Passaic Valley PSRO area neurologists (Figure 1).

There could be no mortality in this group and, as can be seen in Table 2, morbidity was found to be low. No case was found, apart from the seizure group, in which the symptomatology persisted in documented form for more than forty-eight hours. However, sixty patients without complications had a stay exceeding 48 hours.

Despite the low morbidity rate, excessive employment of ancillary services has been documented (Table 3). Two hundred and three separate tests were ordered on this group of 334 patients. The reviewers felt that there was no justification in the record for eighty of these tests.

Fifty-seven percent of these patients were not seen by a neurologist. Unfortunately, the conditions and criteria of our study did not enable the reviewers to correlate the presence or absence of symptoms with neurological findings in this particular group of patients.

DISCUSSION

The medical community long has considered that a history of brief unconsciousness or derangement of the usual level of mental function following trauma to the head can be associated with serious neurological problems. It also feels that such trauma can be associated with subsequent troublesome symptoms which have been characterized as the post-concussion syndrome.

Knowing this, most physicians initially treating such patients are anxious to have them under hospital observation for a period of time. Our prospective study appears to confirm the validity of the first portion of this medical feeling, since a definite percentage (14.1 percent) of patients has been found to have serious neurological sequelae.

While the basis for admission of this group of patients for observation is sound, dependence on symptomatology to measure patient progress and the necessity for accurate neurological evaluation make retrospective judgments about subsequent hospital treatment considerably more difficult.

A brief review of the current literature demonstrates this problem. Rutherford, Merrett and McDonald report on 145 cases of concussion admitted to the Royal Victoria Hospital, Belfast.[2] They note the persistence of symptoms in those patients who "blamed their employers or large impersonal

Figure 1
Cerebral Concussion

	Crt. No.	Elements	Standard 100%	Standard 0%	Exceptions	Instructions and Definitions for Data Retrieval
Justification	1.	Diagnosis: Documentation of temporary loss of consciousness following head trauma or history of head trauma without definite loss of consciousness followed by symptoms of post concussion state including headache, lethargy, dizziness, nausea or visual symptoms.	X			1. If admitted through ER, this may appear on ER record.
	2.	Validated diagnosis justifies admission Critical Diagnostic and Therapeutic Services	X			
	3.	Skull series	X			
	4.	Cervical spine X-ray		X	4. Neck pain or trauma to the neck	
	5.	Brain scan		X	5-10. Persistent lethargy or confusion or severe headache or nausea and vomiting for over 24 hours.	5-10. Exceptions must be found in physicians' notes
	6.	EEG		X		
	7.	ENG				7. ENG = Electronystagmyogram
	8.	Echogram		X		
	9.	CAT scan		X		
	10.	Angiogram		X		
	11.	Neurological consult	X		11. Case admitted by a neurologist.	
Outcome		Discharge Status				
	12.	Fully awake and alert	X		12-14. Deceased	12. Fully awake = "Pt. feels well", "pt. has no complaint"
	13.	Tolerating regular diet	X			13. Reg. diet = That of patient prior to trauma. e.g., in elderly might be a soft diet.
	14.	Ambulatory	X		14. Pre-existing condition preventing ambulation	12-14. May appear anywhere in chart, not only in physicians' notes
Indicators	15.	Mortality		X		
	16.	Length of Stay 48 hours maximum	X		16. One of complications below or non-neurological condition	
		Complications			Critical Preventive and Responsive Management	
	17.	Nausea and vomiting for over over 24 hours		X	17. NPO, IV	17-21. Onseparate sheets, please tally complications by age groups:
	18.	Lethargy		X	18. Bed rest and vital signs q.3 hrs.	
	19.	Confusion		X	19. Bed rest and vital signs q.3 hrs.	a. Age 12 or less
	20.	Seizures		X	20. Anti-convulsant	b. Age 13 or more
	21.	Bleeding or fluid from nose or ear(s)		X	21. Antibiotics and x-rays of skull, base and ethmoid sinuses.	
						20. If necessary, see PDR for anti-convulsants.

"A very large percentage of the retrospective group demonstrated no need for prolonged hospitalization or treatment of any kind."

". . . excessive reliance on a number of expensive ancillary tests was used as a substitute for neurological consultation."

Table 3

	Variations[a]	Deficiencies[b]
Brain Scan	29	11
Electraencephalogram	68	31
Electranystagmagraphy	1	1
Echagram	64	33
Cervical Spine X-ray	41	14
	203	80

[a] Daes nat meet prapased standard on preliminary review. Upan future intensive evaluatian, can be justified ar not depending an adjudicatian af a peer review cammittee.

[b] An unjustified variatian.

organizations for their accidents." Additionally, they found a significant correlation between positive neurological symptoms and signs 24 hours after admission and the persistence of symptoms up to six weeks after injury. In another paper, Relander *et al.* report on a group of patients with concussion, randomly selected to participate in what the authors have characterized as active treatment.[3] The chief features of their treatment are: encouragement to early ambulation, active physiotherapy and followup by the same doctor who admitted them. They make specific reference to the confusion that has surrounded the diagnosis of concussion and find that their "active treatment" significantly has reduced the patient's time off work.

Charged with determining medical necessity and quality of care, Passaic Valley PSRO sponsored this study to determine the clinical handling of this diagnosis in its own area. As can be seen in Table 1, the mortality in the retrospective group is nil. The complication rate appears low with 41 complications found in 334 patients (in a number of instances more than one complication existed in the same patient). Eighteen percent of these patients required hospitalization longer than 48 hours. All others were discharged fully awake and alert, ambulatory and tolerating their usual diet.

A very large percentage of the retrospective group demonstrated no need for prolonged hospitalization or treatment of any kind. Indeed, the recorded treatment was not extensive. There was observation supported by a number of ancillary services. These included skull x-rays, cervical spine x-rays, brain scan, electroencephalogram, electronystagmyogram and echogram. CAT scanning and angiography were not employed in the cases in this study.

The use of radioisotopic brain scans in this set of circumstances is known to be of extremely limited value, as is the the use of echograms in the conscious patient. The employment of these modalities does not appear to be justified.

Due to the structure of the audit (see Table 1) it was not possible to correlate the presence of neurological findings with the procedures ordered. However, the reviewers noted the number of instances in which no justification existed for one or another of these ancillary procedures. Obviously, multiple procedures were carried out in a number of cases. Under the conditions of this study, the absence of some historical data and/or neurological findings would result in a finding of deficiency.

While there was extensive use of ancillary diagnostic tests, 57 percent of these patients were not seen by a neurologist. In a number of cases, there was no apparent need for such consultation since the patient's recorded clinical condition indicated a complete absence of neurological changes or problems of any kind. However, in those patients with positive symptoms or signs (33 percent), it appears that excessive reliance on a number of expensive ancillary tests was used as a substitute for neurological consultation.

Eighty-four percent of the retrospective group did not require any treatment, although they obviously required initial hospitalization for observation as judged by the results of the prospective study. Based on an average per diem cost of $150 for this PSRO area and a stay of two days, this group of 300 cases represents a health dollar expenditure of $90,000. This is the per diem cost and does not take into account an itemized expenditure for the various ancillary services. There is, of course, the additional cost for physician services which is harder to calculate but ranges around $15,000.

On the basis of the prospective study, this group of patients does require a 12 to 24 hour period of hospital observation after injury to rule out serious neurological sequelae.

The existence in this group of previously unsuspected skull fractures speaks to the need for considering the more frequent use of skull x-rays in the management of these cases. Most of these cases did have a skull x-ray on admission.

However, six patients were found in the prospective group in whom skull fracture was not discovered until after admission. It cannot be determined from this study whether or not discovery of a fracture altered the management of these cases.

Since a large number of these patients have been found to require no treatment and to have few, if any, complications, it would appear that an observation period of less than 24 hours could be constructed during which time it should be possible to winnow out the more seriously affected.

The heavy reliance on ancillary tests and the relative lack of neurological consultation may reflect several factors:(1) the treating physician may perceive the patient as having a benign course and not in need of consultation with a neurologist; (2) the doctor wants something more than his statement in the record to reflect this seemingly benign appearance; (3) there may be parental or familial pressure on the physician to "do something" or "make sure that everything is all right;" (4) given the usual time constraints on busy neurologists who are in short supply, the primary physician feels reluctant to annoy him with a rather minor situation.

Whatever the factors involved, it does seem probable, on the basis of the retrospective study, that more involvement of the neurologists through consultation would result in fewer ancillary services for the uncomplicated cases. Futhermore, if Rutherford's investigation has merit, neurological consultation should have additional prognostic value in predicting those patients likely to have persisting symptoms.

Coupling such evaluations with a structured and probably short observational period should be helpful both in reducing the costs of the treatment of this group of patients as well as upgrading the quality of care they receive.

SUMMARY

Under PSRO auspices, a survey of 467 patients consecutively admitted for cerebral concussion in the Passaic Valley area was conducted. This study was carried out both prospectively and retrospectively. The prospective group of 118 cases was studied in terms of the admitting diagnosis and the subsequent pathology. Significant clinical pathology was found in nine patients. Eighty-three percent of the retrospective group of 334 cases were asymptomatic when discharged within 48 hours of admission. Fifty-seven percent of this group were not seen by a neurologist, but were subjected to a variety of ancillary diagnostic tests. Thirty percent of these procedures could not be justified from review of the chart.

On the basis of the minimal treatment recorded and the small percentage of the retrospective group with persisting symptoms or signs, it appears that the health dollar expenditure for this type of patient might be reduced without sacrificing quality of care by hospitalizing them for less than 24 hours, and structuring a neurological consultation and a skull x-ray series into the observation process.

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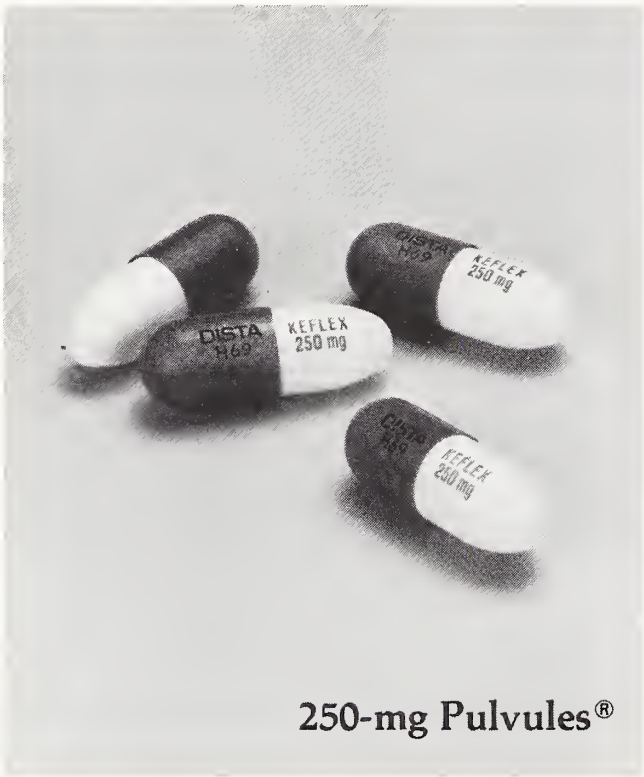

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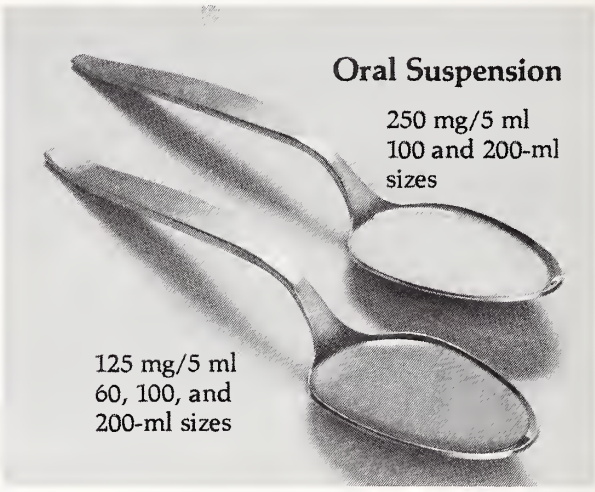

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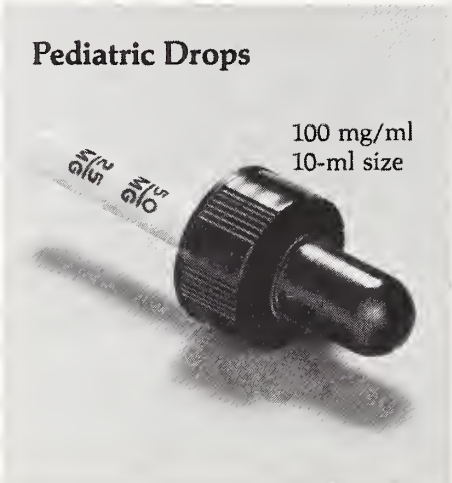

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Gallium Scanning in the Evaluation of Pelvic Lesions

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Gallium-67 citrate scanning recently has been introduced in the detection and localization of inflammatory and neoplastic processes. A positive scan appears as an area of increased radioactivity over surrounding tissues and adds considerable support to a clinical diagnosis of inflammation or tumor. This article illustrates and emphasizes its clinical value in the evaluation of patients with these processes in the pelvis. Clinical experience indicates that gallium scanning is a safe, reliable and sensitive non-invasive diagnostic aid.

Gallium-67 citrate scanning, which recently has been introduced for the detection and localization of inflammatory and neoplastic lesions, lends considerable support to a clinical diagnosis when positive. This is true even when it is not supported by x-rays or ultrasonic evaluation. In many problem cases the only definite diagnostic procedure is surgical exploration.

Gallium-67, a cyclotron-produced radionuclide, has a physical half-life of seventy-eight hours and produces gamma energy suitable for imaging with either scintillation cameras or rectilinear scanners. The radiation dose to tissues is relatively low and within acceptable limits. The whole-body radiation dose is approximately 0.3 rads per millicurie.[1] This material initially was used as a bone scanning agent.[2] In 1969, Edwards and Hayes found that this agent accumulated sufficiently in soft-tissue tumors to allow for their visualization.[3] In 1971, Lavender *et al* demonstrated the localization of gallium-67 citrate in inflammatory lesions.[2] Since then several authors have reported the value of the gallium scan as a means of detecting and localizing inflammatory as well as neoplastic lesions.[1, 5-15]

METHOD

The mechanism of gallium-increased accumulation in neoplastic and inflammatory lesions has not yet been established. Several studies suggest that accumulation is due to an increased amount of gallium-binding material within the disease process rather than a preferential binding of the nuclide.[1,2,5,11,12,14,17] Animal studies have revealed the gallium concentration in tumors to be as high as forty times the concentration in normal tissues. The tumor to blood ratio is as high as 30:1.[18]

The average intravenous dose of gallium citrate ranges from one to five millicuries. Both the Anger scintillation camera and rectilinear scanner usually are used for the localization of the nuclide. The total body scans can be performed 6-24-48-72 hours after the injection of gallium. More frequently they are done 48 hours post-injection, to insure optimal target-to-background ratios.

Free gallium is cleared rapidly from the blood. Following the intravenous administration, 70 to 90 percent of free activity is removed from the blood stream within two hours of administration, the remaining gallium is protein bound and its activity is demonstrable in several tissues. Approximately 20 to 30 percent of the injected gallium is excreted by the kidneys; most of this elimination occurs in the first 24 hours. After the first day, the gastrointestinal tract becomes the major route of excretion. Laxatives and enemas are

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usually administered prior to imaging in an attempt to reduce colonic activity, otherwise confusion in interpretation of results may occur.

A normal scan routinely shows a slight accumulation of the nuclide in the bone and marrow, with the greatest accumulation occurring in the liver. Gallium can be demonstrable in plasma, spleen, bowels, kidney, breasts, and nasopharynx. However, the uptake of gallium is usually sufficient in inflammatory and neoplastic processes in these areas to distinguish them from surrounding normal background accumulation. Gallium scanning has been found helpful in the diagnosis of diverse inflammatory lesions. A positive scan, indicating an inflammatory or neoplastic lesion, appears as an area of increased radioactivity over surrounding tissues, providing an easy means of detection and localization of the process under investigation. Increased uptake has been found in abscess and non-abscess-forming inflammatory processes of the abdominal cavity, retroperitoneal space, breasts, liver, gallbladder, lungs, head, neck, bones, joints, soft tissues, nervous system, kidneys, urinary tract, subphrenic space, spleen, cardiovascular system, gastrointestinal tract and postoperative infected wounds. In relation to inflammatory pelvic pathology, gallium scanning has been found positive in the evaluation of postoperative pelvic abscesses, pelvic inflammatory disease, tubo-ovarian abscess, and postoperative wound infections. Gallium-67 citrate has been shown to accumulate in a large variety of tumors. They include neoplasms of the brain, lungs, breasts, liver, reticuloendothelial system, testes, melanomas, prostate, gastrointestinal tract, pancreas and bone. Several studies have demonstrated the value of this radionuclide in evaluating the presence, absence, or recurrence of neoplastic disease.[1-15] The scanning has been found to be a very non-invasive technique in evaluating gynecologic malignancies.[12]

Although, the current literature pertinent to the use of gallium-67 citrate scanning is quite extensive, an exhaustive review of the obstetrical and gynecological literature failed to reveal publications related to the subject, with the exception of a recent article by Bloomfield *et al.* which supported the use of gallium scanning in gynecologic malignancies.[12]

GALLIUM SCAN IN PELVIC DISEASE: ILLUSTRATIONS

Illustrative gallium scans from six patients are presented (Figures 2-7). The inflammatory lesions are represented by (1) a patient who developed a pelvic abscess after a vaginal hysterectomy (Figure 2), (2) another patient with a left tubo-ovarian abscess (Figure 3), and (3) a patient who developed a wound infection after an abdominal hysterectomy (Figure 4). The malignant pelvic lesions are represented by a patient with adenocarcinoma of the endometrium localized to the uterine body (Stage I) (Figure 5), a case of invasive cervical carcinoma localized to the uterine cervix (Stage I) (Figure 6), and finally, a patient with carcinoma of the right ovary (Stage I) (Figure 7). In all instances the diagnoses were confirmed surgically and histologically. For comparison a patient with a normal gallium scan is presented (Figure 1).

Figure 1—Normal gallium scan. The scan above shows body background activity with slight accumulation in the spine and pelvis and the maximum accumulation of the nuclide occurring in the liver (L). Symphysis pubis (S). The abdomino-pelvic area shows no abnormal uptake.

Figure 2—Positive gallium scan. The scan shows increased midpelvic activity due to a pelvic abscess which developed after a vaginal hysterectomy (PA).

DISCUSSION

Nuclear medicine isotopic techniques have become important non-invasive diagnostic procedures. The localization of an inflammatory process can be difficult prior to surgical exploration. Effective management of patients with inflammatory processes depends on an accurate diagnosis and prompt therapy. Clinical evaluation, laboratory tests, cultures, radiologic, and ultrasonic procedures may fail to localize the abnormality. The use of the gallium scan as a

Figure 3—Positive gallium scan due to a left tubo-ovarian abscess (TOA). The scan shows increased uptake of the radionuclide in the left lower quadrant. Liver (L).

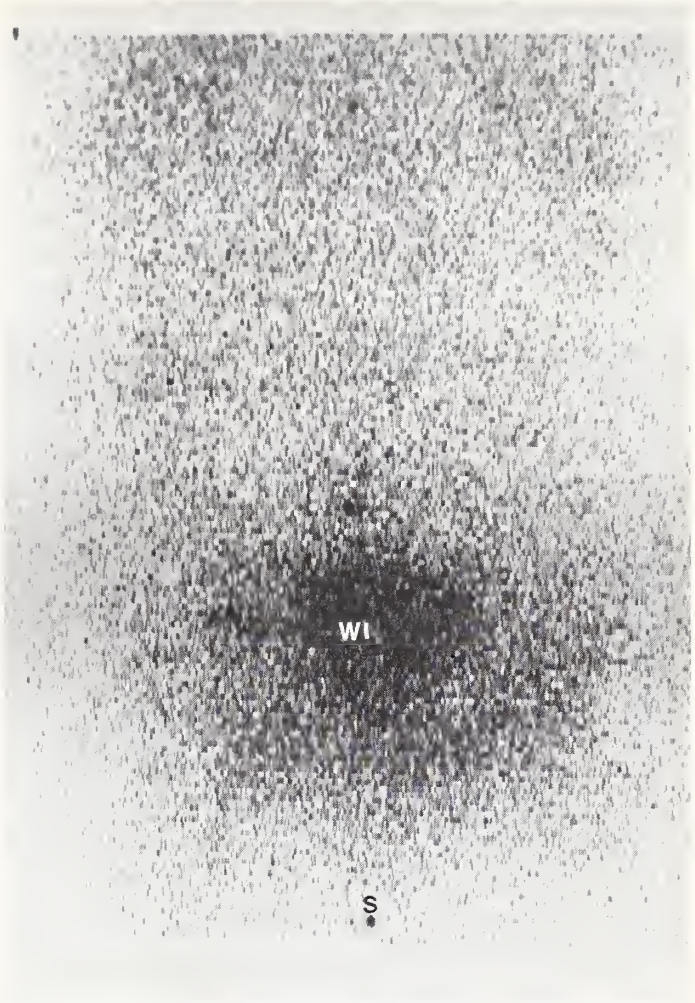

Figure 4—Positive gallium scan due to a wound infection (WI). The patient underwent a total abdominal hysterectomy, bilateral salpingo-oophorectomy and appendectomy for treatment of leiomyomata uteri. The postoperative course was complicated by an abscess of the abdominal wall secondary to infection of the Pfannenstiel incision. Symphysis pubis (S).

positive marker of sites of sepsis adds considerable support to a clinical diagnosis of abscess. The scan provides a reliable indication of the location and size of the infected areas. Furthermore, negative scans in patients with evidence of sepsis suggests that a localized focus is not present, or that its size may be too small to be detected, or that the inflammatory lesion is resolving satisfactorily. The fact that gallium-67 citrate concentrates in both inflamed tissue and frank abscesses is a definite advantage over the ultra-sound scan, which is unequivocally positive only if a walled-off abscess has been formed.[19]

There is a low incidence of false-negative and false-positive scans in reported series of patients with inflammatory processes.[1,4-8,10,11] False-negative results are primarily related to insufficient target-to-background ratios. Consequently, the preferred technique is to delay gallium scanning for 24 to 72 hours after intravenous administration to ensure optimal target-to-background ratios for optimal differentiation. Recent studies have demonstrated that there is no need for routine delay of the scan in septic patients.[1,4,7] Scans obtained as early as two hours after the intravenous injection have shown high concentration of radioactivity due to the avidity of gallium-67 citrate for inflammatory sites. An additional advantage of early scanning is the ability to image the abdomen without undue interference from colonic activity. Some bowel activity may be seen on early scintigrams though it is not nearly as pronounced as in studies 24 hours or after. Early scannings are particularly helpful in patients in whom cathartics are contraindicated.[1] It seems reasonable

Figure 5—Positive gallium scan due to uterine tumor (UT). The scan shows increased pelvic activity in the right lower quadrant. The pelvic activity was associated with adenocarcinoma of the endometrium (Stage I). Liver (L); symphysis pubis (S).

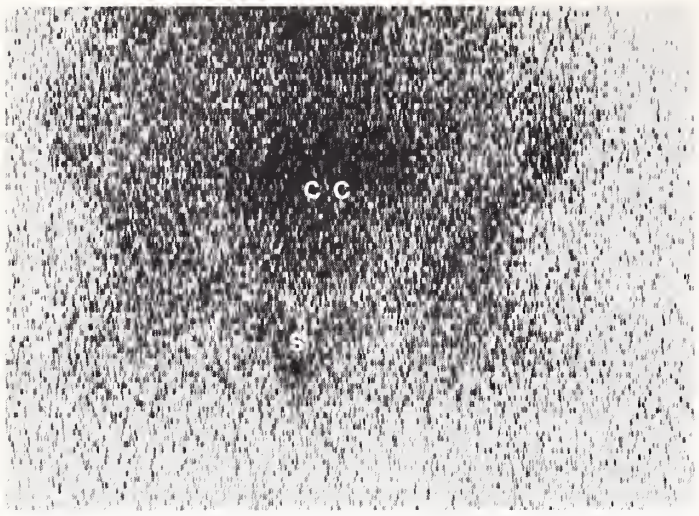

Figure 6—Positive gallium scan due to cervical cancer (CC). The scan shows increased midpelvic activity. The increased uptake of the gallium-67 citrate was associated with invasive carcinoma of the uterine cervix (Stage I). Syphysis pubis (S).

Figure 7—Positive gallium scan due to an ovarian carcinoma (OT). There is heavy accumulation of the radionuclide in the right lower quadrant which was associated with a carcinoma of the right ovary (Stage I). Liver (L), symphysis pubis (S).

to perform early scannings in septic patients and, in cases where the results are negative or questionable, delayed studies then should be obtained. This approach can be expected to lead to the rapid identification and localization of abscesses and other focal inflammatory processes.

False-positive results are usually due to error of interpretation because of persistent activity in the large bowel. Scans with apparently abnormal uptake in areas that could represent colon must be interpreted with caution. When the septic area is near the liver, kidneys, bowels, or bladder, the accumulated radioactivity occasionally may be difficult to define as specific accumulation secondary to sepsis. Another potential source of error is an abscess in a septic patient with cancer. In this case the interpretation must be non-specific, and the chief value of gallium scanning may be the exclusion of the diagnosis of abscess when the test is negative or in indicating further diagnostic studies when focal abnormal accumulations are found.[7] Careful attention to technique and cautious interpretation significantly reduce false-positive and false-negative results.

Since 1969 when Edwards and Hayes[3] noticed the accumulation of gallium-67 citrate in tumors, this radiochemical has received considerate attention as a tumor-scanning agent.[2,4,6,13,20] Recently, Bloomfield *et al.* have reported the value of gallium scanning in patients with gynecological malignancies.[12] An increased uptake of gallium by a pelvic mass supports the diagnosis of cancer. In addition, the scans can demonstrate metastatic involvement in unsuspected areas; its use after cancer therapy can reflect the response to treatment by conversion from a positive scan to a negative one.

Conversely, the failure of a positive scan to convert to a negative one may indicate the persistence of active neoplasm.[4] False-positive scans in patients with neoplastic disease may be caused by inflammatory lesions or focus of activity in the lower gastrointestinal tract. Other factors may include arthritis, Paget's disease, fractures, craniotomy or skin incisions. False-negative scans usually are caused by insufficient target-to-background ratios, but other factors may include necrotic lesions, the presence of marked fibrosis in the lesion, failure of the tumor to take up the gallium, and the size of the lesion (less than two cm in diameter).

We evaluated the gallium scan in twenty-six obstetrical and gynecological patients with proven benign and non-inflammatory pelvic processes. Our results indicate that benign and non-infectious pelvic conditions do not show an increased uptake of the nuclide. An important observation from a clinical point of view was the absence of gallium uptake at the site of non-infected surgical incisions in the postoperative period.[21]

Inconclusive scans may be caused by inadequate preparation of the bowel.[12] Ultrasonography and gallium scans have a complementary role rather than a competitive one in the diagnosis of infections and tumors. When a pelvic mass is discovered, pelvic ultrasound provides accurate information concerning the size, structure, and location. The accurate determination of whether the mass is benign or malignant cannot be made ultrasonically. The complementary use of gallium scan will help to determine the neoplastic or non-neoplastic nature of the mass. An increased uptake of the lesion supports the diagnosis of cancer. In addition, the scan may show metastasis involvement in unsuspected areas. Both techniques have proved their accuracy in the localization of inflammatory processes. Ultrasound is unequivocally positive only if a walled-off abscess has been formed. Small or incipient abscesses may be overlooked, and it is difficult to make the diagnosis in areas in which inflammation is present but frank pus formation yet has not occurred. A significant advantage of gallium scan is its capacity to concentrate in abscess and non-abscess-forming inflammatory processes. In addition, the scan will determine inflammatory areas in unsuspected places. The complementary use of both techniques offers a comprehensive non-invasive evaluation.[22]

SUMMARY

Gallium-67 scan is a safe, accurate, non-invasive diagnostic aid which should be used in the evaluation of patients with suspected inflammatory or neoplastic pelvic lesions. The results are helpful in determining the best approach to definite diagnosis and therapy of infectious and malignant processes.

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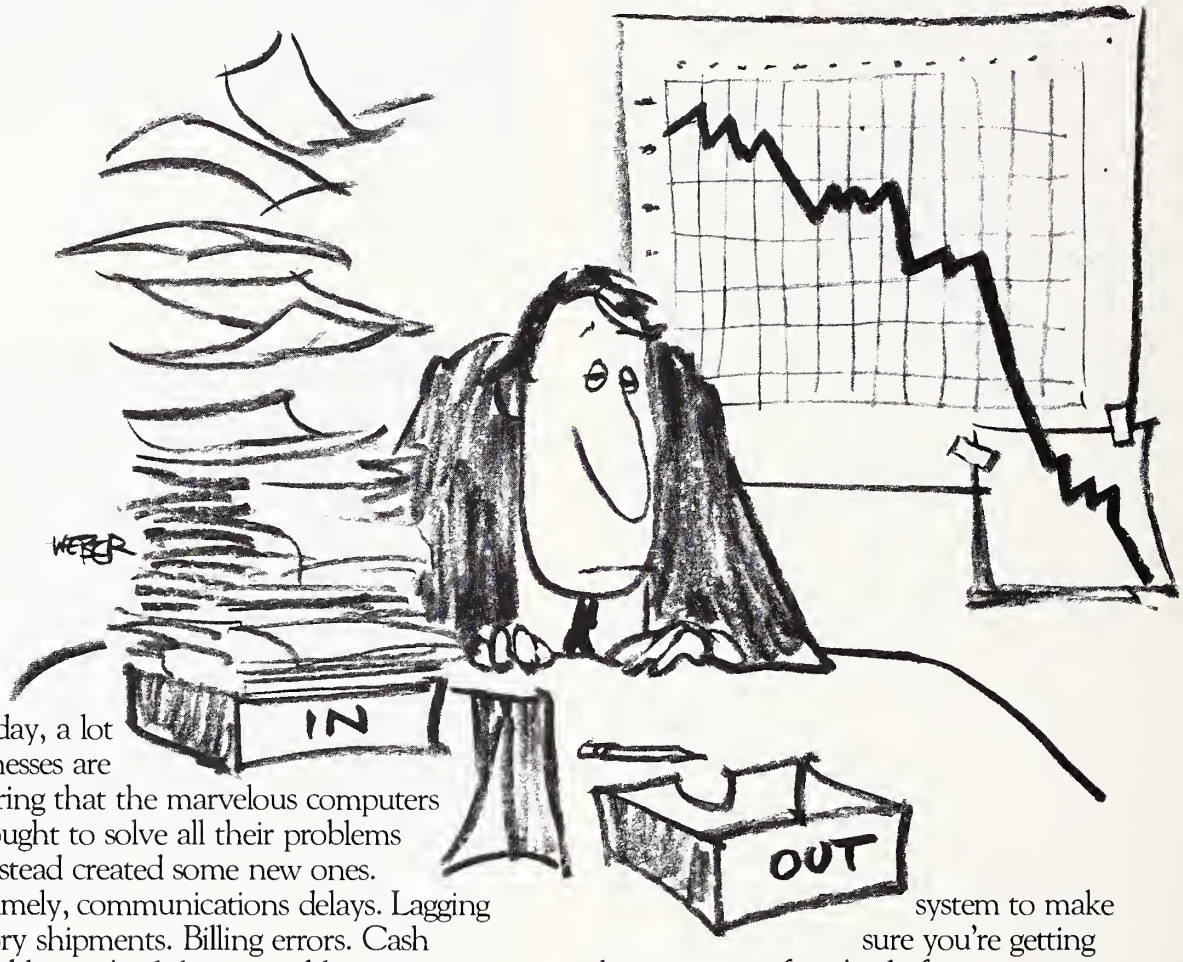

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REVIEW ARTICLE

Membranous Nephropathy

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Membranous nephropathy is the most important primary renal disease causing the adult nephrotic syndrome. Its distinction from other disorders presenting in this way has important clinical implications. A significant association with underlying neoplasms and renal vein thrombosis has been demonstrated. In addition, therapy may prevent progression to chronic renal failure.

BACKGROUND AND DIFFERENTIAL DIAGNOSIS

The nephrotic syndrome is a clinical entity characterized by peripheral edema, proteinuria (greater than 3.5g per day), hypoalbuminemia and hypercholesterolemia. Its presence (or the presence of "nephrotic range" proteinuria) implies a glomerular rather than interstitial, vascular or obstructive renal pathology.

In children the majority of patients with the nephrotic syndrome have minimal change disease (NIL disease or lipoid nephrosis). Because of this high frequency, treatment often is empiric and further evaluation is done only if there is no response to corticosteroids.

In adults, however, the spectrum of likely diagnoses is much greater, encompassing "primary" glomerular disorders as well as secondary causes of the nephrotic syndrome due to a variety of systemic disorders, most commonly diabetes mellitus, systemic lupus erythematosus and amyloidosis. The primary glomerulopathies leading to the nephrotic syndrome in adults with their approximate frequencies are minimal change or lipoid nephrosis (15%), focal glomerulosclerosis (15%), various proliferative glomerulonephritides (20%) and membranous nephropathy (50%). Thus, membranous nephropathy is the most common primary renal disease resulting in the nephrotic syndrome in adults.

MEMBRANOUS NEPHROPATHY: CLINICAL PRESENTATION

Membranous nephropathy may be seen at any age though the peak incidence is in the fifth and sixth decade. There is a slight but not impressive male predominance. The nephrotic syndrome is the presenting manifestation of approximately 75 percent of patients with membranous nephropathy.[1,2,3] The remainder usually are evaluated because of non-nephrotic proteinuria. Microscopic hematuria occurs in 50 to 60 percent of patients though gross hematuria is quite unusual. In a recent series of 116 patients with membranous nephropathy (all but seven over 15 years old) none had a history of gross hematuria.[1] In a series of 66 individuals (56 adults, 10 children) three children and one adult had gross hematuria.[3] In a pediatric study of membranous nephropathy 11 of 50 children had gross hematuria suggesting that hematuria occurs more commonly in this age group.[4] Thus gross hematuria in adults with the nephrotic syndrome should raise strong suspicions of a diagnosis other than membranous nephropathy. Hypertension is usually absent at the onset of the disease, but increases in frequency (25 to 58 percent) later in the course.[1] It is usually mild and easily controlled with the usual anti-hypertensive medications. In the typical patient, renal function is normal or slightly impaired early in the course of the disease, though there are

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"The nephrotic syndrome is the presenting manifestation of approximately 75 percent of patients with membranous nephropathy."

"Hypertension is usually absent at the onset of the disease, but increases in frequency (25 to 58 percent) later in the course."

many exceptions to this. Presentation with a significant degree of renal failure is not rare. Serum complement levels are almost always normal.[3]

PATHOLOGIC FINDINGS

The three criteria for pathologic diagnosis of membranous nephropathy are (a) thickening of glomerular capillary walls, (b) absence of proliferation of cells in the glomerulus and (c) a presence of subepithelial and/or intramembranous deposits by light or electron microscopy (Figure). The anatomic lesion has been divided into three or four stages by several workers based upon the number and size of the deposits and the thickness of the basement membrane.[5,6] Correlations between histologic stages, renal function and prognosis have been attempted with varying success. In the individual patient the pathologic stage is not a good indicator of the clinical course of the disease.[3,7]

PROGNOSIS

Approximately 25 percent of patients with membranous nephropathy will be in a remission after four to five years of observation.[1-3,7] About 15 percent of patients will have reached end-stage renal disease and require hemodialysis or transplantation after this same period of time with an additional similar sized group probably reaching the same point in another five years. The remaining patients, after five years of observation, will have changed very little from onset —their renal function may have declined and their proteinuria increased or decreased. It appears likely that proteinuria not in the nephrotic range has a better prognosis with respect to progression to renal failure than proteinuria of a greater amount.[3]

TREATMENT RESULTS

The success of therapy is difficult to assess because of the 25 percent spontaneous remission rate and the very gradual progression of the disease. The value of corticosteroids and/or immunosuppressive therapy has not been clarified.[8-11] A major prospective study of this problem is currently underway. Preliminary results suggest that prednisone (2mg/kg on alternate days for two months) significantly decreases the likelihood of progression to renal failure. One of 38 patients in the treated group versus 11 of 45 patients in the control group doubled their serum creatinine during a two-year followup period.[12]

EXPERIMENTAL MEMBRANOUS NEPHROPATHY

Membranous nephropathy essentially identical to the human disease may be induced in rabbits after the injection of one to five mg of bovine serum albumin.[13] That amount of albumin is necessary to induce the membranous nephropathy since immune complexes of a particular size (less than one million daltons) must be generated; such particles can cross the basement membrane in the glomerulus and deposit in a subepithelial location. Interestingly, it is only a subgroup of rabbits with a low level of antibody response to the bovine albumin that develop membranous nephropathy. Recent work suggests that patients with membranous nephropathy also have a diminished capacity to produce normal amounts of antibody when compared with normals and patients with uremia or with the nephrotic syndrome of another cause.[14] This suggests that the quantity of immune complex reaching the glomerulus is an important factor in the development of this disorder. It may be that a low level of immune complexes does not result in the intense inflammation and proliferation that may occur with higher levels of immune complexes.

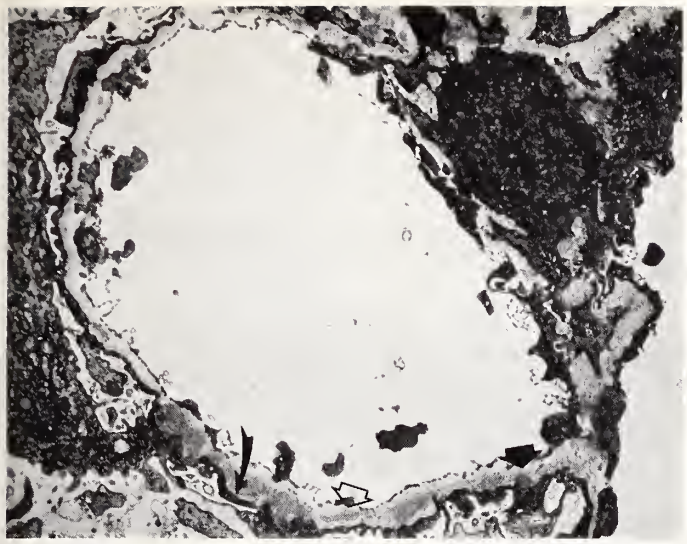
The antigen in these experimental membranous nephropathies can be identified in the glomerulus while in most patients with membranous nephropathy the antigen is not known. In some, membranous nephropathy occurs in association with a specific disorder (Table) so antigens related to the underlying disease can be sought. In several of these disorders such an antigen has been identified. For example, in syphilis, treponemal antigen has been identified in the glomerulus. Hepatitis B virus has been implicated as well. In a Japanese study of 163 children with proteinuria or hematuria, eleven were found to have membranous nephropathy.[15] Hb_sAg was found in the serum of all eleven but in only seven of the remaining 152 children with other renal diseases. Hb_eAg recently has been identified as the antigen deposited in the glomeruli in two of these patients.[16]

Another experimental model of membranous nephropathy is in rats given injections of homologous kidneys in Freund's adjuvant. The antigen-antibody complex in this model results from autoimmunization against a component of the brush border of the proximal tubule. This renal tubular epithelial antigen has been identified in four of nine patients with idiopathic membranous nephropathy[17] though this observation remains unconfirmed by other workers.[18,19] Glomerular deposition of renal tubular epithelial antigen also has been found in membranous nephropathy associated with renal cell carcinoma, renal vein thrombosis and sickle cell disease (though membranoproliferative glomerulonephritis is the usual lesion found in sickle patients with the nephrotic syndrome).

Doubts about the immunopathogenic significance of circulating immune complexes in idiopathic membranous nephropathy have been raised. Such complexes are not found in the majority of patients with membranous nephropathy and, when present, often can be explained by other associated disorders. It, therefore, has been suggested that in-situ formation of immune complexes in the glomerulus is responsible for this disorder.[19]

ASSOCIATED PROBLEMS

The nephrotic syndrome results in a hypercoagulable state.



Figure—Electron micrograph (x 10,000) of a cross section of a glomerular capillary in a patient with well-developed membranous nephropathy. Subepithelial (closed arrow) and intramembranous (open arrow) deposits of immune complexes are apparent. Foot process fusion (curved arrow) is diffuse.

Reports of increased generation of thromboplastin, decreased fibrinolysis, increased circulating plasmin inhibitors and an increase in factors V, VII, VIII and X have appeared in the literature. Probably because of this and because of intravascular volume contraction there is an increased tendency to thrombosis including involvement of the renal veins. But, for unclear reasons, the likelihood of renal vein thrombosis complicating the nephrotic syndrome seems to depend on the underlying kidney disease.

It has been widely accepted in recent years that it is the nephrotic syndrome that precedes the renal vein thrombosis rather than the reverse in virtually all cases.[20] A literature review of patients with renal vein thrombosis and the nephrotic syndrome in which renal histology was known showed 75 percent of 87 patients had membranous or membranoproliferative glomerulonephritis. In a prospective study, 98 patients with the nephrotic syndrome were studied by inferior vena cava and renal venography.[20] Of those patients whose nephrotic syndrome was due to membranous or membranoproliferative disease 41 percent had renal vein thrombosis. Of those with the nephrotic syndrome due to another cause only eight percent had renal vein thrombosis. Other studies have confirmed this high incidence of renal vein thrombosis with these two underlying kidney diseases (with only one discordant report[21]). A high degree of clinical suspicion for this complication should be present although the use of anticoagulant therapy in asymptomatic patients is controversial. Pulmonary emboli may occur as a result of these thromboses.

Over the past few years a high degree of association between cancer and the nephrotic syndrome has been noted. The initial report found an association malignancy in eleven percent of 101 adult patients with the nephrotic syndrome.[22] Subsequent studies reported a similar incidence. The kidney abnormality in the majority of such patients with an associated carcinoma is membranous nephropathy with a reported incidence of 64 percent.[23] Hodgkin's disease also may be associated with the nephrotic syndrome, but, in this disorder the renal histology is usually minimal change disease. Carcinomas of the lung and gastrointestinal tract account for most of these cases. At least ten other types of carcinoma also have been reported in association with the nephrotic syndrome. There is considerable evidence that tumor-related antigens and the patient's antibody response to them are the cause of the membranous nephropathy in many individuals. Circulating immune complexes have been found in a high percentage of patients with various neoplasms.[24] Antigens which appear to be tumor-related have been eluted from the glomeruli of these patients. Immunoglobulin, which has a specific reactivity to antigens prepared from the resected tumor, also has been found in these glomeruli. Of considerable clinical importance is the fact that the nephrotic syndrome usually presents before the diagnosis of the tumor. In 42 reported cases, the nephrotic syndrome preceded the diagnosis of the tumor in 19 cases and followed it in seven cases; it was noted simultaneously in 16 cases.[23] Thus, strong consideration to the possibility of an underlying neoplasm should be given in patients presenting with nephrotic syndrome as a result of membranous nephropathy, particularly those at increased risk for carcinoma.

Table

Clinical Conditions Associated with Membranous Nephropathy

Systemic Lupus Erythematosus
Neoplasia
Penicillamine
Heavy Metals (Mercury, Gold)
Syphilis
Malaria
Leprosy
Filariasis, Schistosomiasis
Hepatitis-B, Chronic Active Hepatitis
Sarcoidosis
Sjogren's Syndrome
Chronic Allograft Rejection
Sickle Cell Disease

SUMMARY

Advances in several areas of research involving membranous nephropathy have made this subject a suitable one for review. Progress has been made in assessing the value of therapy with corticosteroids, in recognizing the high frequency of associated renal vein thrombosis and neoplasm and in understanding the pathogenesis of the disorder. Nephrologists hope that future advances will allow a better understanding and management of patients with this disorder.

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CASE REPORTS

Myocardial Infarction with Normal Coronary Arteries*

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A 44-year-old woman sustained an acute myocardial infarction but coronary arteriography performed two months later revealed patent vessels. The patient had been receiving a combination of drugs. A prominent finding at the time of admission was marked sustained sinus tachycardia. This case may represent an example of myocardial infarction due to extreme imbalance of myocardial oxygen supply and demand in the absence of fixed obstructive coronary artery disease.

Acute myocardial infarction without evidence of atherosclerosis is an infrequent clinical event that has attracted considerable attention. Various explanations have been offered, and it is likely that several mechanisms may cause sufficient imbalance of myocardial oxygen supply and demand as to produce infarction.[1]

CASE REPORT

A 44-year-old female clerk was admitted to Bergen Pines County Hospital on November 12, 1976 because of palpitations and a choking sensation, all of which started while at work on the day of admission. Because of tachycardia, she was given 0.5 mg. of digoxin orally by her private physician and was referred for admission.

Admission blood pressure was 120/90 mm. Hg.; sinus tachycardia at a rate of 150/min. was present. Cardiac size was within normal limits. There was no evidence of congestive heart failure nor thyrotoxicosis. A summation ventricular gallop was noted on auscultation.

Since 1970, she had been receiving perphenazine-amitriptyline (Triavil® 2-25), one tablet, twice daily for anxiety and depression. She had discontinued cigarette smoking five years earlier.

For the past five years, she had been treated for mild hypertension with alphamethyldopa and chlorothiazide (Aldoril® 25 or Aldochlor® one tablet daily). Three years previously she was diagnosed as "premenopausal" by her obstetrician and estrogen (chlorotrianisene 25 mg. daily) was prescribed.

Six months prior to admission, she was given L-thyroxine (Synthroid®) 0.1 mg. daily, because of extreme weakness and "low" T-3 RIA of 23.1 percent (normal 25-35 percent). The dose of Synthroid® was increased to 0.2 mg. daily because of persistently low T-3 RIA and since then she noted frequent episodes of rapid cardiac action.

Six days prior to admission her blood pressure was found to be 150/100 mm. Hg. and she was started on apresoline 25 mg. and hydrochlorothiazide 25 mg. (Apresazide® 25/25) twice daily. Admission electrocardiogram revealed evidence of an acute, transmural, anterior wall myocardial infarction, with new Q waves in Leads I, aVL, V2 to V6. Within the next few days, the QRS abnormalities disappeared and serial ECG and VCG tracings demonstrated evolutionary changes of an acute extensive subendocardial myocardial infarction (Figure 1).

Serial creatine phosphokinase and lactic dehydrogenase isoenzyme examinations were consistent with acute myocardial necrosis. The maximal total CPK was 673 IU with a maximal CK-MB of 56 percent. Maximal total LDH was 490 mu/ml (LDH 145.1 percent, LDH 2 32.6 percent). Additional laboratory testing, including thyroid function and lipid analysis, was within normal range.

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Coagulation Profile

	10 Weeks Post Infarction (off Estrogen)	14 Weeks Post Infarction (on Estrogen)
Platelet Count (175,000 - 500,000 mm^3)	750,000	500,000
Antithrombin III (Quantitative)	110%	93%
Xa Inhibitory Activity	78%	73%
PT (Quick one-stage) (12'' - 14'')	13.2	12.2
PTT (35'' - 45'')	39.4	33.5
Fibrinogen (150-350 mg. %)	251	256
Factor II	105%	165%
Factor V (75-150%)	135%	138%
Factor VII-X	110%	112%
Factor VIII (50%-200%)	250%	–
Platelet Aggregation Studies	Normal	Slight delay in secondary wave with epinephrine.

Normal values in parentheses

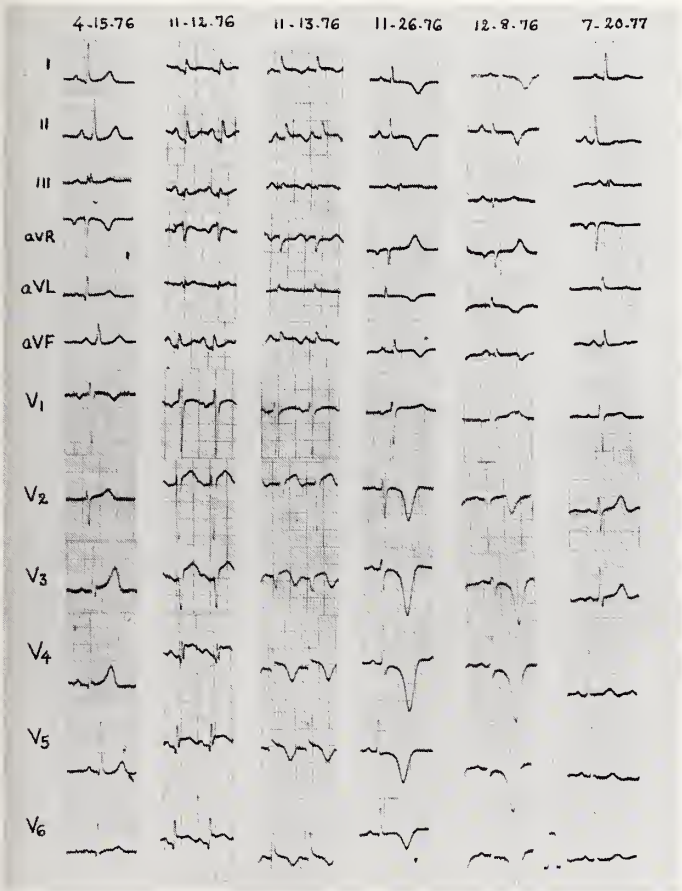

Figure 1.—Serial electrocardiogram.

On the second hospital day a pericardial rub was audible. Persistent sinus tachycardia responded to small doses (10 mg. QID) of oral propranolol. Systemic pressure ranged between 90 and 120 mm. Hg. systolic.

The patient's hospital course was uncomplicated and she was discharged two weeks later on isosorbide dinitrate tembids 40 mg. BID, propranolol 5 mg. p.o. q six hours, aspirin 600 mg. o.d. and hydrochlorothiazide 50 mg. o.d.

An atrial gallop sound was still present two months later. A high frequency, Grade I/VI, mid-systolic murmur, best heard over the apex in left decubitus position, was first heard on June 8, 1977 and is still present.

Selective coronary arteriography was performed on January 13, 1977 (Figure 2) and demonstrated patent, smooth-walled coronary arteries, minimal impairment of contraction of the left ventricle which was of normal size, and evidence of a state of decreased compliance of the left ventricle, as manifested by elevations of LV end-diastolic pressure up to 35 mm. Hg. following angiography, rapidly declining to a resting value of 15 mm.Hg.

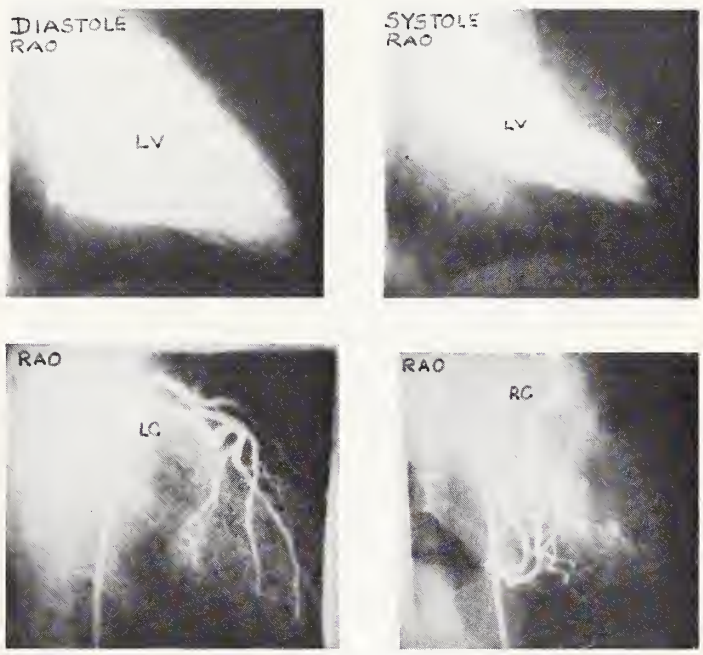

Figure 2—Top: Left ventriculogram (LV). A—End diastolic frame in right anterior oblique (RAO) projection. B—End systolic frame in RAO projection. Bottom: Coronary arteriography. C—Left coronary artery (LC) in RAO projection. D—Right coronary artery (RC) in RAO projection.

Coagulation studies were not performed at the time of infarction, but three months later, with the patient off all medications, these studies revealed thrombocytosis and slightly diminished Xa inhibitory activity (Table 1). Estrogen (chlorotrianisene 25 mg. daily) then was resumed and the coagulation studies repeated one month later were unchanged.

DISCUSSION

Among the various mechanisms that have been postulated to explain myocardial infarction in the absence of obstructive coronary artery disease are the following: thromboembolism with subsequent lysis or recanalization of clot, acute platelet aggregation, spasm of coronary arteries, diseases of the microcirculation, abnormal oxyhemoglobin equilibrium and other conditions associated with altered myocardial oxygen requirements relative to supply.[1] Initially, our patient presented with electrocardiographic findings suggestive of acute transmural anterior wall infarction. Subsequent electrocardiograms failed to demonstrate abnormal Q waves, but rather, were consistent with extensive subendocardial infarction. It has been suggested that severe ischemia is capable of producing transient Q waves because a portion of the myocardium becomes temporarily inert or electrically silent.[2]

"... among the clinical conditions associated with subendocardial necrosis are extreme myocardial mass, profound anemia, low perfusion pressure,[1] carbon monoxide poisoning[4] and abuse of catecholamines.[5]"

"Several epidemiological and clinical studies have indicated increased risk of myocardial infarction and postulated various etiologies in women receiving oral contraceptives or estrogen.[6,7,8]"

Extensive subendocardial infarction is unlikely to have been caused by extensive spasm, thrombosis, or embolism of a single coronary artery; rather it is consistent with a more diffuse process. The subendocardium is particularly vulnerable;[3] among the clinical conditions associated with subendocardial necrosis are extreme myocardial mass, profound anemia, low perfusion pressure,[1] carbon monoxide poisoning[4] and abuse of catecholamines.[5] None of these factors was present in our patient. Inspection of the serial electrocardiographic changes virtually excludes myopericarditis as a cause of electrocardiographic changes. The observation of marked sinus tachycardia at the time of admission in the absence of systemic hypertension, congestive heart failure, or diminished cardiac output, might be related to the combined effect of multiple drugs. This marked sinus tachycardia certainly resulted in increased myocardial oxygen requirements, although, the double product (heart rate times systolic blood pressure) was not excessive at that time. In addition, the acute administration of digoxin at the onset of symptoms, albeit by the oral route, may have further increased myocardial oxygen demand. Hydralazine, L-thyroxine and perphenazine-amitryptyline all increase sympathetic activity and, thereby, may exert a positive inotropic and chronotropic effect. It is conceivable that other mechanisms may have been operating simultaneously with increased myocardial oxygen demand.

Several epidemiological and clinical studies have indicated increased risk of myocardial infarction and postulated various etiologies in women receiving oral contraceptives or estrogen.[6,7,8] Estrogens may alter clotting mechanisms by virtue of increased activity of factor VII and, to a lesser degree, factor X. Increased platelet adhesiveness and a direct effect on vessel walls also have been described.[9,10] Spain *et al.*[11] studied the pathogenesis of fatal myocardial infarction in young women who had been using oral contraceptives. Each case showed freshly ulcerated atheroma with adherent thrombi. The atheromatous core was in the process of dissolution and resembled the ulcerated lesions produced experimentally in chicks by estrogens. They postulated that estrogens initiate a disruption of the atheromatous core which in turn leads to platelet aggregation and thrombosis. Rapid dissolution of such an obstruction is likely, so that arteriography performed weeks later might fail to demonstrate a fixed abnormality. Diminished antithrombin III[12] and Xa inhibitory activity[13] have been described in women receiving oral contraceptives suggesting that this may be a significant factor in the tendency of these individuals to thrombosis.

Our patient had been taking estrogen for three years prior to her infarction. Other than the observation "platelets adequate" at the time of admission, specific coagulation studies were not performed until three months after infarction, at which time all medications had long been discontinued. At this time, moderate thrombocytosis was present but coagulation studies were normal. Quantitative determination of antithrombin III levels was normal, although Xa inhibitory activity was slightly diminished which in turn may indicate a hypercoagulative state. When the patient was rechallenged with estrogen for one month, the coagulation profile was unchanged from previous results suggesting that estrogen-related hypercoagulability was not a primary factor in this case.

Thrombosis occasionally has been associated with myocardial infarction in patients with hematologic disorders characterized by thrombocythemia.[14,15] Patients with thrombocytosis of various causes may have hyperactive platelets with circulating platelet aggregates that are subject to spontaneous thrombosis. Platelet aggregation in our patient was normal, although these studies also were not performed at the time of admission. Platelet aggregation in coronary arteries has been reported to produce ischemia and tissue injury. It is conceivable that acute and transient platelet aggregation, either in an epicardial coronary artery or in the microcirculation, might have been responsible or contributory to the sequence of events observed in this case.[16,17]

Increased sympathetic activity may increase platelet aggregability, and associated with tachycardia or substantial hypotension, it may cause relative underperfusion of the inner layer of the myocardium. The latter may cause impaired myocardial performance, lactate production and abnormal electrocardiographic changes. Stellate ganglion stimulation has been shown to reduce the inner/outer flow ratio in the myocardium.[18] These potential changes, in the face of increased myocardial oxygen requirements because of tachycardia and increased inotropism, may have been a contributory factor in inducing subendocardial ischemia in our patient. Once initiated, severe subendocardial ischemia has a tendency to perpetuate itself, by inducing an increase in resistance of subendocardial layer coronary vessels, thus shunting blood away from the subendocardium toward the subepicardial layer.[19] These observations in experimental animals, though entirely speculative in the human, may explain the sequence of events in our patient.

Although the elements for iatrogenically-induced exag-

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". . . severe subendocardial ischemia has a tendency to perpetuate itself, by inducing an increase in resistance of subendocardial layer coronary vessels, thus shunting blood away from the subendocardium toward the subepicardial layer.[19]

gerated myocardial oxygen requirements were present one would expect associated diminished blood supply in order for extensive infarction to occur. That coronary arteriography failed to reveal obstruction does not preclude this possibility as sufficient time elapsed between the clinical event and the study to permit resorption of platelet thrombus or embolism; provocative tests to rule out transient coronary spasm were not performed. Similarly, the coagulation studies and platelet function tests were performed three months following the infarction. Nevertheless, neither significant platelet dysfunction nor defects of the antithrombin III system were demonstrated even after the rechallenge with estrogen.

Our patient remains asymptomatic and well eight months after her acute infarction and the electrocardiogram has reverted to normal, with the exception of low amplitude T waves in I, aVL, V5 and V6. This points to the transient nature of the pathophysiologic mechanisms operative in this case. In large series of patients with ischemic heart disease and patent coronary arteries, the clinical course tends to be benign although a number of exceptions have been recorded.[20]

SUMMARY

A 44-year-old woman developed subendocardial infarction and had patent coronary arteries on subsequent arteriography. The latter presumably was due to a confluence of factors each of which was capable of increasing myocardial oxygen requirements by accelerating the heart rate or by a positive inotropic effect. Among the drugs being used at the time of infarction were hydralazine, perphenazine, amitriptyline and L-thyroxine. In addition, the patient had been taking estrogen for three years prior to the acute episode; it was suspected that this may have been a significant factor in causing a reversible coagulopathy. Extensive coagulation tests performed three and four months following the infarction documented only mild thrombocytosis and slightly diminished Xa inhibitory activity. However, these abnormalities were not affected by reinstitution of estrogens and their significance in the pathogenesis of this patient's infarction is undeterminded.

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The Calcified Pineal Gland: Failure of Displacement with Unilateral Cerebral Masses*

ALLEN SILVERSTEIN, M.D., Ridgewood

Two patients with unilateral cerebral hemisphere neoplasms and calcified undisplaced pineal glands are described. Lack of lateral displacement of calcified pineal gland may not be sufficient to exclude a unilateral cerebral mass lesion.

In these days of computerized tomographic scanning (CT) and sophisticated neuroradiology, there is a growing tendency to minimize—or ignore—the plain skull roentgenograms and the position of the calcified pineal.

Most neurologists and neurosurgeons believe that a midline, non-displaced pineal gland in the Towne's projection of skull x-rays would usually exclude a unilateral cerebral mass lesion. While the occurrence of a midline pineal gland with bilateral intracranial lesions, such as bilateral subdural hematomas and multiple metastases is well known, a lateral shift of the pineal gland, when visible on skull roentgenography, has been thought to indicate a unilateral cerebral mass. The finding of a midline, non-displaced pineal gland probably has led to abandonment of further neurological investigations of unilateral cerebral symptoms and signs in many patients.

The purpose of this communication is to report two patients who were found to have unilateral cerebral neoplasms and well-calcified pineal glands which were not displaced in the skull roentgenograms, AP or PA projections.

CASE REPORTS

Case 1—A 61-year-old right-handed man was hospitalized with progressing speech difficulties for three weeks and mild headaches for two weeks. He had trouble reading and recognizing letters, but there were no other neurological symptoms. There was no pertinent past history.

The detailed general physical examination was normal. The only abnormalities on neurological examination were limited to speech. He was dysphasic and dysnomic and had considerable difficulty with spontaneous speech.

Spinal fluid protein was 73 mgs/dl. An electroencephalogram and radionuclide brain scan showed left temporal abnormalities. The skull roentgenograms were normal with a midline pineal gland (figure 1). However, computerized tomographic scan showed a left temporal mass lesion, which intensified with contrast enhancement (figure 2). A left carotid arteriogram revealed a malignant stain deep in the left posterior temporal region (figure 3). Attempts to seek out a primary malignancy, including barium enema, upper gastrointestinal series, intravenous pyelogram, repeated chest roentgenograms and bone scan were unrevealing as were all blood investigations.

Because the lesion was felt to be deep in the dominant left temporal hemisphere, malignant, and therefore inoperable, the patient was treated with corticosteroids and radiotherapy with some improvement, which was maintained for five months. He died suddenly of a massive pulmonary embolus. At autopsy, the neoplasm in the left temporal region (figure 4) was shown to be an infiltrating astrocytoma. There was no involvement of the right hemisphere.

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Figure 1—Case 1—Towne projection of skull. The pineal gland (arrowhead) is not displaced.

Figure 3—Case 1—Left carotid arteriogram showing malignant stain (arrowhead) in the left temporal lobe.

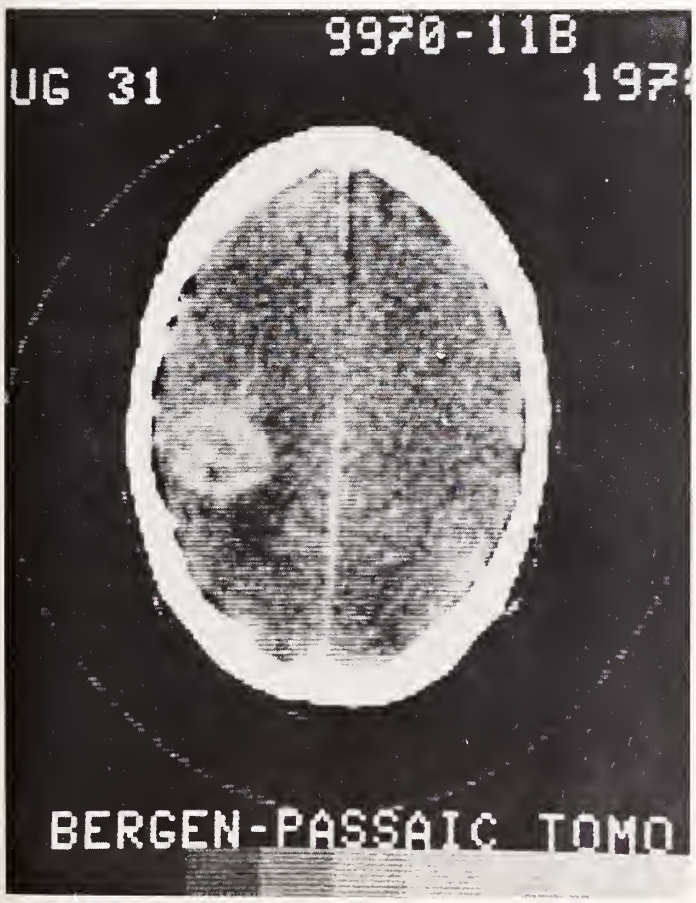

Figure 2—Case 1—CT scan showing left temporal neoplasm.

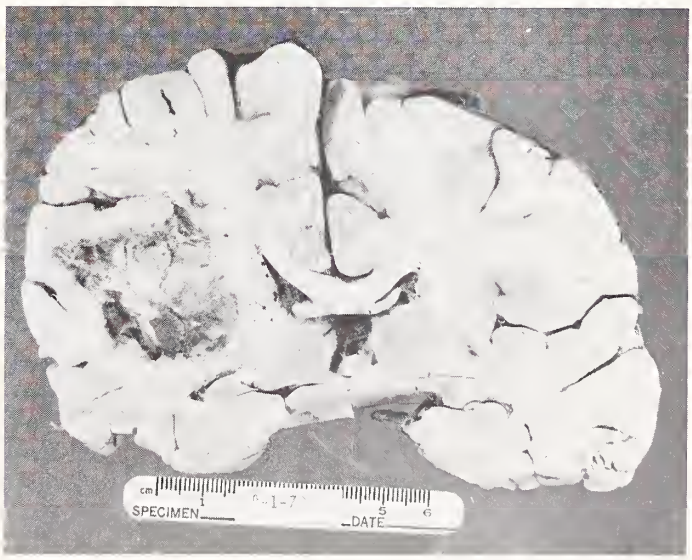

Figure 4—Case 1—Section of brain at autopsy showing infiltrating astrocytoma in the left temporal lobe.

Case 2—A 59-year-old man was seen because of twitching movements of the left side of the face and a left facial palsy. These symptoms had started suddenly on the day of the neurological consultation. The past history was significant in that a melanoma had been excised from his right shoulder one year before. The detailed general and neurological examinations were normal but for a left facial palsy.

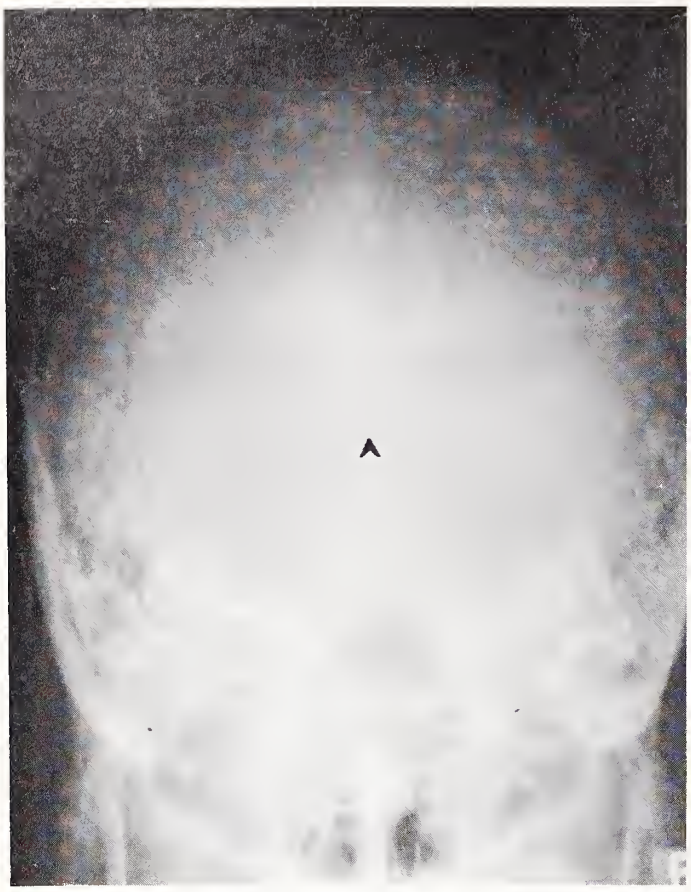

Figure 5—Case 2—Towne projection of skull showing non-displaced pineal gland (arrowhead).

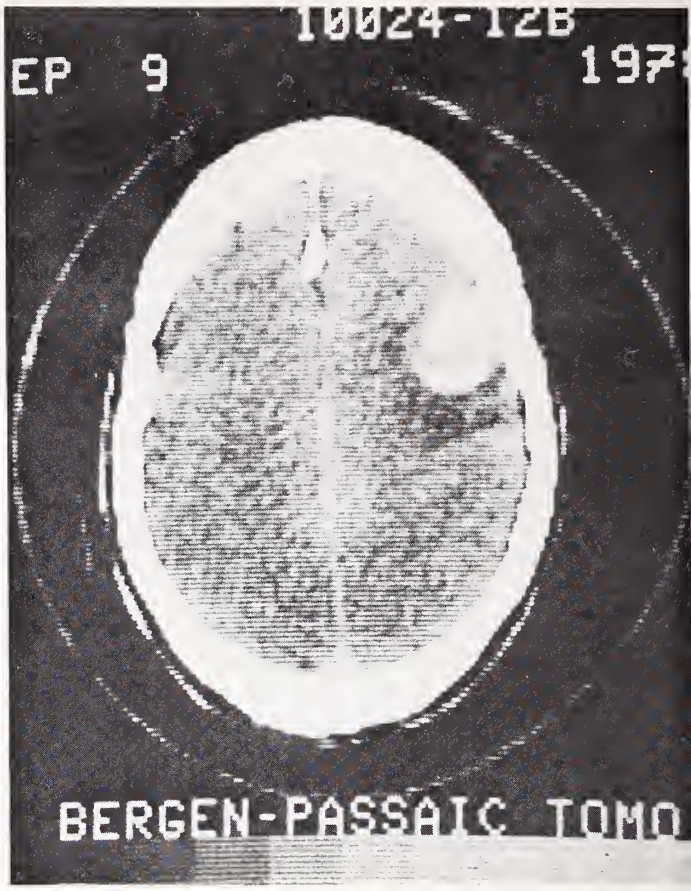

Figure 6—Case 2—CT scan showing neoplasm in the right posterior frontal-parietal area.

An electroencephalogram obtained as an outpatient was normal. Skull roentgenograms were also normal with a midline calcified pineal gland (figure 5).

The next day the patient developed headache and increasing twitches involving the left side of the face and then the left arm and leg. He was hospitalized with focal left status epilepticus which was controlled with intravenous medication. There was a left hemiparesis which lasted for about ten minutes after the seizures were controlled. The left facial palsy persisted. The remainder of the examination was normal.

A radionuclide brain scan revealed a right frontal-parietal mass which was confirmed by CT scan (figure 6) and right carotid arteriography (figure 7). Steroid and anticonvulsant medication was begun. Extensive laboratory investigation, including urinary and spinal fluid melanin determinations, were negative. The mass, which was superficial in the non-dominant hemisphere, was excised and proved to be a metastatic melanoma. The facial palsy improved following surgery. The patient continued to take anticonvulsant medication, and has remained completely normal on a six-month followup examination.

DISCUSSION

Because of its ready availability and low cost, roentgenographic examination of the skull still plays a role in the neurologic investigations of patients with cerebral disease, even in this age of computerized tomographic scans and other esoteric technical advances. The clinician who finds a calcified midline pineal gland on skull x-ray usually can be reasonably certain that a unilateral hemispheric mass has been excluded. However, in the two patients reported here, the pineal gland was calcified and not displaced despite unilateral cerebral neoplasms.

Figure 7—Case 2—Right carotid arteriogram showing mass effect in the right posterior frontal-parietal area (arrowhead).

Case one had an astrocytoma in the posterior temporal lobe but the clinical and x-ray data, including CT scan and autopsy failed to show involvement of the other hemisphere. Only two days elapsed between the normal skull x-ray

(showing a midline pineal gland) and the CT scan and carotid arteriograms which showed a left temporal mass. There was no significant deterioration in the patient's condition during this interval and nothing to suggest a sudden hemorrhage or acute edema to explain why the pineal gland was not shifted.

While case two did have a metastatic melanoma in the frontoparietal region, there were no clinical or roentgenographic abnormalities involving the other hemisphere. The time intervals between the skull x-ray and CT scan and arteriograms were two and three days respectively. Neither the CT scan nor surgery nor lumbar puncture suggested a hemorrhage. The only clinical change in the patient after the skull x-ray was the onset of seizures, which were well-controlled.

CONCLUSION

It would appear, therefore, that on occasion, a calcified midline pineal gland may not be reliable for the exclusion of a unilateral mass lesion of one cerebral hemisphere. In such cases, further investigation is necessary.

SPECIAL ARTICLE

Medicine Then And Now

STANLEY S. BERGEN, JR., M.D., Newark*

It is my pleasure and distinct honor to address the recipients of the Golden Merit Award. I have been asked to talk about medicine as it was when you started in practice and how I see the delivery of health care under the aegis of the physician of the future. I am not sure that I have the credentials either to reflect completely upon the past or to see accurately into the future. So many factors change from day to day, week to week and year to year, that it is hard to be sure of one's predictions. However, without showing the fear that I probably should, I will attempt both tasks.

First, let me assure you that I do have some knowledge about the past, not only by virtue of my own age and the experience of more than 25 years of practice, medical education and administration, but also because my grandfather, Dr. Elston Bergen, was a practicing physician in Princeton, New Jersey, for almost 60 years. He, too, would have received the Golden Merit Award if it had been given in the early 1930s, since he practiced till his death at age 84 and, in fact, saw 25 patients on the day of his demise.

That Dr. Bergen was noted around Princeton for his various modes of transportation. A sketch was printed in the local newspaper depicting some of these activities. For example, he would have my father place a log at the entrance to his barn, so that when he fell asleep in his carriage coming home from a night call, the log would cause the wagon to bounce and awaken him: much to his embarrassment, many times he found himself sitting in the barn sound asleep while the horse calmly ate hay from supplies left at the beginning of the day. Later in life he was the owner of one of the first automobiles in Princeton, and many stories are told about his ability or lack of ability to drive the car. A recent issue of *Antique News* noted that he once cranked the car while it was in gear only to have it back up the steps of the First Presbyterian Church.

Another time he told the family a story about his visit to a farmhouse on a Sunday, where, much as the doctor in the famous painting on a stamp issued in the 1940s, he "maintained the vigil." At the end of a full day of watchful waiting and the delivery of a healthy young son to the farmer's wife, he was asked by the farmer the cost of the delivery. My grandfather told him that it would be $20. The farmer believed that excessive. My grandfather noted that he had taken his entire Sunday in order to assure the birth of a healthy child; the farmer grudgingly paid the $20. Upon backing out of the farmer's driveway, my grandfather's rear wheel slipped into a ditch. The farmer came running out and immediately offered to help pull my grandfather from the ditch. The farmer brought his team of oxen to the scene and pulled out my grandfather's car with great ease. As my grandfather was beginning to move his car forward, the farmer waved him down and noted that he usually gave his oxen a rest on Sunday, and that therefore the fee for pulling Dr. Bergen from the ditch would be $20.

It seems I can remember some of these events myself—I did make rounds up to the age of six with my grandfather on Saturdays—and I remember with fond affection his visits to our local pharmacy, and how my grandfather and Mr. Landor would discuss various medications, including calomel and sugar pills. Upon graduation from college I notified my third cousin, Dean Willard Rappelye, of my admission to medical school at Columbia University College of Physicians and Surgeons. I had refrained from indicating my relationship to him prior to my acceptance, fearing that those kinds of communication can cut both ways. He wrote me an interesting letter, noting that the first two relatives of our family to enter Columbia medical school were notorious for their tenure: the first was dismissed for drunkenness and the second was terminated for keeping bawdy women in his room.

Over the last few years there have been many books written about medicine, past and future, including McKeown's *The Role of Medicine,* Illich's condemnatory *Medical Nemesis,* and, most recently, a book by David Rogers called *American Medicine.* All attempt to put into perspective the past accomplishments of the medical profession and also glimpse into the future. Critics and admirers alike observe that many health-care problems which you faced as new graduates will not face graduates of today. You and your colleagues have solved them.

A half century ago the average doctor could, and I quote Roger Egeberg's words to a White House Conference on Health, "sit with the patient, pray with him and hold vigil with him and the family. But, beloved as he was, when it came to actual therapeutic measures, he had very few in his pocket."[1]

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*President of the College of Medicine and Dentistry of New Jersey. This presentation, written jointly by Dr. Bergen and Amy C. Roth, Assistant to the President, CMDNJ, was delivered at the Golden Merit Awards Ceremony of the Medical Society of New Jersey, May 22, 1980, Lawrenceville. A list of the recipients is included at the close of this article.

Today our once-homely profession is a potent and sophisticated industry. The advances of the late nineteenth and early twentieth centuries—in antisepsis, asepsis, anesthesia and the nature and use of vitamins, antibiotics and other powerful medicaments—have been followed, during the practice years of those we honor today, by giant strides in diagnosis, through the CT scanner and radioisotope techniques, in chemotherapy, in genetics and in immunology—the list is nearly endless.

Medicines and therapies now exist to assuage sickness and pain which did not exist when you started. Epidemics which caused death or lifelong suffering in the past—polio, smallpox, measles, others—threaten us no more. Babies who once would have died now live and flourish. It comes to mind that the Kennedy baby, Patrick, who succumbed to hyaline membrane disease less than 20 years ago, now might be treated and go home with his parents to begin a life.

Problems of the mind which, during your early practice years, condemned human beings to living death now can be controlled, and sometimes cured. For these miracles the nation and the world must give profound thanks to you and your generation of researchers and healers.

So, in this important way, because of you, today's new doctors confront an easier task. But in other ways their task remains as difficult and complex.

We live in an age of increasing egalitarianism, of mistrust of science and the professions in general, of a sociopolitical complexity never before approached, and of no-longer-limitless resources. All of these factors impact on our profession and on our future colleagues. The desires and dreams which drive the physician, to be sure, are the same for the new generation as for yours—as Dean Tosteson of Harvard Medical College has expressed it, "the faith and hope that we can do something about the problems that limit our lives."[2] And some of the means now pursued to achieve these ends—while at first seeming to be different—are really "old wine in new bottles." But some ways and means for the physicians of tomorrow must be different from before, because the world is different. People still want something special from their doctors—but not quite the same thing as in the past.

To begin, where once the doctor was looked on as a near God—where once the task of "cure" was seen as his alone, both by himself and by his patients—the doctor of tomorrow must see his role as that of a team player. The most important player on the team, moreover, will be the patient himself. People of today demand not just *not* to be *sick*, but to be *consciously* well and *feeling* well. To achieve such a level of health, the patient himself must finally be the major agent of change. The person has a responsibility for his own good health.

In a second way, too, the doctor of tomorrow will be more of a team player than in the past. The cooperative medical enterprise is replacing the independent proprietor of your early practice years. When you and your colleagues set out to practice, more than nine out of every ten American physicians were engaged in full-time primary care. Some 84 percent of American doctors described themselves as general practitioners. But as succeeding medical generations set out to conquer the burgeoning body of knowledge, they found it no longer practical to try to master it all. So increasing numbers of physicians over the past 35 to 40 years have instead learned all they could about what interested them most. By 1975, not even *four* out of every ten American doctors were engaged in primary care, and as few as 15 percent called themselves GPs.

This trend to specialization was quite natural—self-protective, even. But an unforeseen side effect developed. While doctors now specialized, they still retained the independent spirit which traditionally marked the physician. They remained for the most part individual proprietors. This led unwittingly to fractionalization of patient care. Fewer and fewer doctors were treating the whole patient, more and more the particular part in pain or disabled. The patient himself began to make his own referrals, trying to diagnose his problems himself and approach the proper specialist.

To right this situation, today's young practitioners are giving up some of that old independence. Increasingly they are learning to practice in groups, or "firms," generalists and specialists together, supplying among them comprehensive counsel for each patient. This trend toward group practice is not brand new. As recently as 1965, only ten percent of American physicians practiced together despite the increasing domination of specialization. Only in the last 20 years has the American Medical Association ceased active opposition to this mode of practice, and the Association has championed the cause fairly consistently since the 1960s.

So, I think, in the name of better all-around patient care, doctors must and will become less individualistic. We have been soloists; we are becoming ensembles.

This brings us to a third recent shift in medical practice—although in this case it is partly a return to an earlier mode. I refer to emphasis on treatment of the whole person rather than primarily on some anatomical or physiological part. No patient is a physical being alone. Each of us is also a psychological, social and—yes—a spiritual being. Doctors are recognizing this afresh. We are becoming respectful of what our predecessors never forgot—that factors other than the physical have physiological consequence.

Another current change—and another prime example of a turn *back* to where medicine began—is that people are seeking from doctors not solely their knowledge, but also their wisdom. People today are searching from many sources for wisdom about the process of life. I believe they would like to turn to their doctors for this wisdom, as in days past. And I think it appropriate that doctors should be able to impart such wisdom—wisdom to help not only to preserve, but also to enhance, human life. After all, the term "doctor" does mean "learned man" or—even more accurately—"teacher." In this context I was interested to read, in a recent book on the history of medicine, the opinion that today's physician "frequently enters practice more as a scientist than as a humanist." The book decried the doctor's tendency to be "more responsive to the challenge of a complex problem in diagnosis and treatment than to the seemingly trivial complaints . . . that bring most patients to the doctor."[3] Dr. Jerome K. Freedman, recent president of the Connecticut State Medical Society, states it in even stronger terms. "I find my colleagues technically capable, scientifically well-trained and usually expert technicians," he says. "But they are often inadequate historians, philosophers and ethicists."[4]

The prominent medical philosopher Lewis Thomas prescribes for improvement as follows. We must, he says, "look forward to a generation of doctors who have learned as much as anyone can learn . . . about how human beings have always lived out their lives. Over the bedrock of [such] knowledge about our civilization, the medical schools [can] then construct as solid a structure of medical science as [can]) be built. But the bedrock [will] always be there, holding everything else upright."[5]

Such thinking already has affected the medical-school admissions process. Certainly, we still look for evidence of scientific promise: doctors always will need to be scientists. But—possibly more than the public is aware—we now look more closely at other things: indications of interest in the broadly human [side of life], rather than solely in what can be seen beneath a microscope, indications that a young person is capable of social leadership and a philosophical perspective. We need doctors who can live up to the original meaning of their title. Many physicians find it difficult to talk to their patients about cancer and other terminal diseases. This must change.

At the College of Medicine and Dentistry of New Jersey, we have acknowledged this new emphasis even to the point of tampering with that holy of holies, the medical curriculum. Four years ago, we hired a Harvard-trained theologian to begin a series of programs in the health-care humanities. These programs and lectures, mostly in medical ethics, have become some of the most popular of our student activities, even when not graded and for no credit. The most appealing and popular course is "Ethics for Lunch." Clearly, our CMDNJ students recognize that more than technical ability is necessary for their future careers.

Recently the Hastings Center celebrated its tenth anniversary. This center was developed to assist in the interface between the scientific knowledge of health care and medical practice and the ethical principles of our profession. A feeling had existed that science had overcome existing ethics in health care; the Hastings Center is attempting to restore the balance.

None of this comes a moment too soon. For, as I said earlier, one of the greatest changes all society is experiencing is the near exhaustion of what we always thought were limitless resources. The pie is getting smaller just as everyone's appetite has been whetted most. No one is willing any more to put up with being sick. But no longer will anyone hand the doctor a blank check. So now we are grappling with the demanding task of reconciling opposed, assertive social attitudes. This means that the new doctor will have to make hard ethical choices—and sometimes political ones too—which his forefathers did not have to confront. He will need that broad education, that habit of thinking broadly, in practice. He will be overwhelmed without them.

Let me, then, list the issues that will challenge tomorrow's physicians:

1. **Sharing of the health-care role:** It may go down hard with many solo practitioners of yesterday, but in the future the team effort will be paramount. Many types of professionals will be on the health-care team, and such shared responsibility will bring diverse leadership and new direction.

2. **Humanism joining science:** Technology has dominated medicine for the last quarter century. The caring physician, in the future, once again will be in great demand. Regionalization of health services will help make technology available to all, but it will be used in a more humanistic context, with fuller recognition of the humanity of both physician and patient.

3. **Cost containment:** We know our resources are finite, and—like it or not—this heralds choices such as who shall live and who shall be helped? The public will continue to clamor for control of health-care costs; while such costs may seem beyond the physician's control, they are actually within his control to a good degree. The physician will make more choices in terms of cost, and will also have to educate his patients to all the implications of choices based on cost.

4. **Government intervention:** This is inescapably the way of life of the future. We must resist it when unnecessarily costly, but accept and even welcome it when it can be expected to help the doctor attain his ends. It is the hardest thing in the world to tell one from another, especially in advance. We must become more thoughtful on this issue.

5. **Emphasizing primary and ambulatory care:** We must give greater attention to careers in primary care for young graduates. We must stress ambulatory care and limit our emphasis upon the in-patient and on specialized medicine.

6. **Emphasizing physician supply by geography and by specialty:** The Canadians have noted that the addition of one health-care professional to an already well-served area does not improve the quality of health care for the residents but merely increases its cost. One of the key questions facing our nation now is, how many new physicians are needed, and where should they practice?

7. **Charting the future of the public health-care facility:** The fate of the public hospital seems in the balance. The question is not whether it should survive but a broader one: how will people without resources receive the health care which most agree is their due? The burdens now being placed upon voluntary institutions, in a time of rate review, cost containment and regulation threaten to bring two irresistible forces into headlong collision.

8. **Playing politics with health:** Unfortunately, health-care issues such as who gets into medical school, who practices medicine, where, and how, have gained increasingly political flavor of late. While public voicing of health-care issues is certainly beneficial at best, it can be destructive at worst. I am hopeful that the medical profession will not sully itself by use of strike threats and other political maneuvers—that it will participate politically when necessary but always keep the patient's welfare paramount.

I am sure each of you can think of many other changes in the way medicine will be practiced—the involvement of previously excluded groups including women; the changes which national health insurance, or some facsimile, will create. But I will mention just one more factor for change—one which bears on all the others. I mean **the inevitable increase in doctors' participation in non-medical life and in greater communication with the public at large.**

Although we doctors retain our high public regard, the level slips a little each year, tarnished by such issues as Medicaid fraud. Part of the problem, I am sure, is what Jacques Barzun identifies as the fall from grace of *all* scientists since Hiroshima.[6] But doctors, particularly, with their close relationships with the general public, have tended to be so professionally preoccupied in the recent past, that the public confidence on which they have thrived traditionally is on the wane.

Society is dissatisfied with *many* aspects of health care today—including the doctors. And they have reason for concern. For despite the scientific advances of the last half-century, *adult* life expectancy has barely budged. A man who managed to attain the age of 45 in 1900 could expect to live until 69. A 45-year-old man today can look forward to living only some four years longer than before.[7]

The National Center for Disease Control expects the next 20 years to bring little more of the dramatic successes in disease control which have marked the practice years of our guests of honor. As the Center reports, today's top killers are not infectious diseases, but rather *chronic* conditions, *violence, accidents* and the like.[8] These relate not so much to the scientific knowledge of the doctor, but to the life style of the

patient. Even more, they relate to conditions of society at large—political and economic as well as social.

American medicine is not accustomed to focusing on political and social issues such as these. But it must. There is no question that doctors must begin talking to other social leaders as well as to one another. We all know that the medical profession is coming under increasing public control —but how much are the actions of public institutions influenced by members of the medical profession? I doubt our effect has been maximal.

What effort could be more relevant to the practice of medicine? What better way for the new generation to stand on the shoulders of those of you here, who fought the earlier battles, than to take on the new ones? I think the new generation is willing and even eager to come to grips with the social conditions which are as potent as germs were in shortening lives and stealing people's health.

Much of what I have called "change" has, on reflection, not been change at all from 50 years ago. But neither has it been a strict return to an earlier day. It has been less a circle, I think, than a spiral. We *do* know more today, and we build our practices on that greater knowledge. But while we have been learning, we have also been forgetting—forgetting attitudes toward our patients as people, toward ourselves as people, toward the reasons why we value life enough to try to prolong it. These are things your generation remembered.

What a patient seeks is someone who listens, someone who cares. It is no different today than yesterday. The physician can be such a person: one committed to a life of hard work and sacrifice—not only by the individual but by his family! Yet I am sure you will agree, on looking back, that the rewards are worth the sacrifice—the rewards of helping others, of pursuing the most fulfilling of professions.

My final prediction will be a hope: that doctors will continue to be men and women of science, like their fathers and mothers; but that, like their grandfathers, they also will remember to be men and women of soul.

It has been a joy to join you today and to have such free reign to muse on the past and future of health care. I reassure you that my batting average as a sooth-sayer has never achieved national note; I have no crystal ball. My comments have been merely observations and contemplations. In future days, it may be fun for all of you to be able to point out that "Bergen was wrong."

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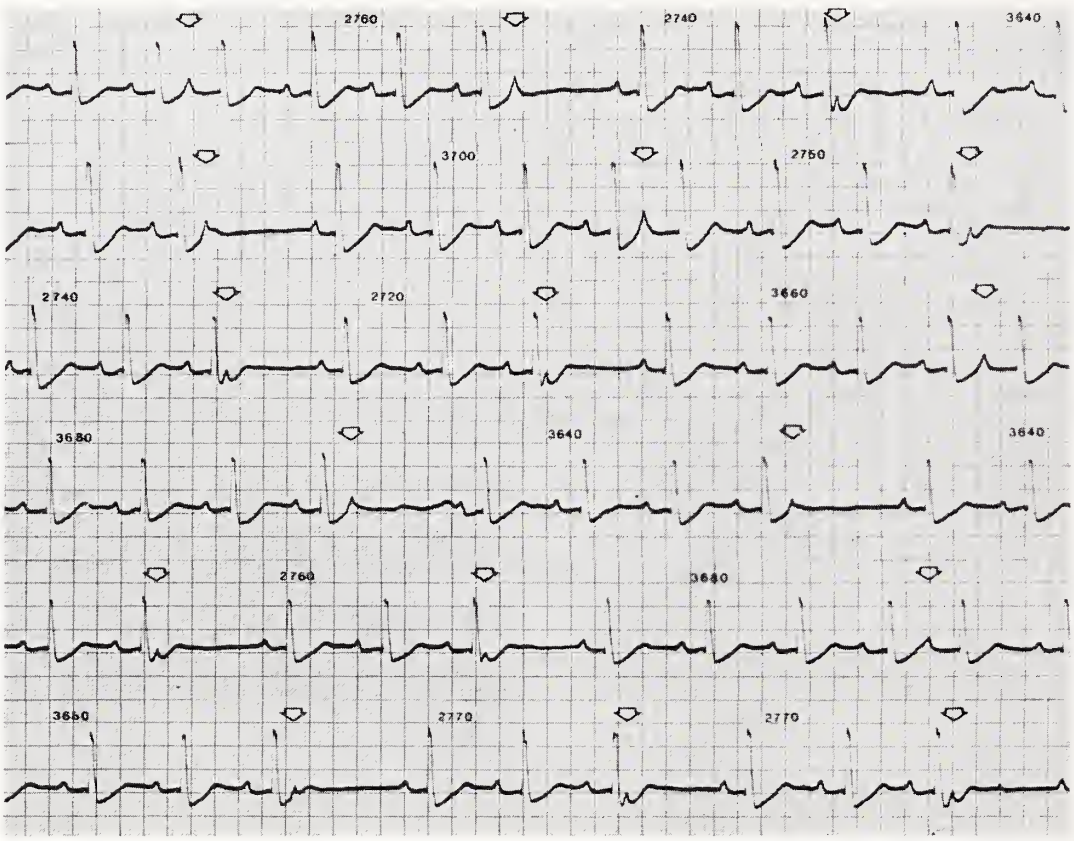
Atrial Parasystole

SHASHI K. AGARWAL, M.D., Newark*



The rhythm strip (continuous Lead II) was recorded from a 65-year-old female who had a long-standing history of hypertension and congestive cardiac failure, and was admitted to Bergen Pines County Hospital with a left lower lobe pneumonia. The basic rhythm is sinus at a rate of 75 per minute. Interspersed are seen numerous atrial premature complexes (arrows) exhibiting varying coupling intervals to the immediately preceding sinus beat. Some of the atrial ectopic beats are conducted to the ventricles, while most are blocked at the AV node. The interectopic intervals are either 2.7 seconds or 3.6 seconds and are simple multiples of 0.9 second. These findings are diagnostic of atrial parasystole.

CHARACTERISTICS

Parasystole results from the existence of a second center of impulse formation in addition to the basic pacemaker controlling the heart.[1-5] Since its first description by Kaufman and Rothberger in 1921,[6] parasystolic foci have been recognized in different areas of the heart.[7-9] The description of atrial parasystole, however, has been restricted mainly to isolated case reports.[4,5,7,9] It is a much rarer dysrhythmia than ventricular or atrioventricular nodal parasystole. Rarely, the simultaneous presence of two parasystolic foci may occur,[10-12] while a unique entity of sinus parasystole is said to exist when the sinus node exhibits a unidirectional protection block in the presence of ectopic atrial depolarizations.[13]

Atrial parasystole is characterized by the presence of a unidirectional protection block lying within it or in its immediate vicinity and operating during both the refractory, as well as the nonrefractory phase of the parasystolic focus. The result is ectopic impulses irregularly punctuating the basic rhythm, with inconstant coupling intervals and with interectopic intervals that are either equal to or are simple multiples of one another. The last mechanism results due to the following reasons. Although the ectopic focus usually fires continuously at a fixed rate, all impulses are not manifest on the surface electrocardiogram because (a) the

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parasystolic depolarization is unable to propagate if the surrounding myocardium is still refractory after activation by the other pacemaker or (b) there is a Mobitz type II exit block in the immediate vicinity of the parasystolic focus preventing its escape although the surrounding myocardium is non-refractory.[14,15] This latter phenomenon is evident in about 25 percent of cases of atrial parasystole and was probably present in my patient. Its presence is often difficult to recognize due to spontaneous inter-ectopic interval variability, which may be as much as 0.27 seconds.[3]

The parasystolic focus in this patient presumably fired at a rate of 70 per minute while the sinus rate was 75 per minute. Although, the ectopic firing rates in atrial parasystole may vary from 17 per minute[10] to 375 per minute, [15] most are slower than the sinus rate. This was seen in my patient. Further, the P wave of the ectopic focus usually bears a close resemblance to the sinus P wave [2,4,7] and the dysrhythmia in my patient confirmed this observation. The similarity of the ectopic P wave to the sinus P wave as well as the occasional occurrence of postectopic intra-atrial conduction aberration,[4] however, prevents easy recognition of fusion beats, the presence of which fortifies the diagnosis of atrial parasystole.[3] The actual incidence of fusion beats, nevertheless, remains low in atrial parasystole,[7] with only a few cases having reliably demonstrated this phenomenon.[4,5,7]

DIFFERENTIAL DIAGNOSIS

Atrial parasystole must be distinguished from atrial ectopic beats occurring in a non-parasystolic fashion, atrial dissociation and artifacts. Unifocal atrial ectopic beats occur with constant coupling intervals while multifocal atrial ectopics will show varying P wave morphology, varying P-R intervals and interectopic intervals which bear no relationship to one another.[16] Atrial dissociation can be distinguished by the lack of conduction of ectopic impulses to the ventricles during all phases of the cardiac cycle, smaller ectopic P waves, more variable interectopic intervals and usually an association with severe cardiac disease.[17] Artifacts may have characteristics resembling atrial dissociation and, although often perplexing, their presence can be ruled out by careful observation of the patient for precipitating factors such as hiccups, myoclonic jerks, and others.[18]

ETIOLOGY AND TREATMENT

Atrial parasystole is usually transient and does not seem to be associated with any particular disease entity. On the basis of the similarity of the ectopic to the sinus P wave and the presence of ectopic P-R intervals which are almost equal to the sinus P-R intervals, Friedberg and Schamroth have postulated the ectopic focus to be fragments of sinus tissue dissociated during embryonal development and lying close to the sinus node or along the main atrial conduction pathways.[2] It is also possible to hypothesize, on the basis of recent histological studies by Scherf and James, that atrial parasystole results from rate acceleration of a normally present dormant subsidiary atrial pacemaker.[19] Although digitalis often is incriminated,[20] the presence of atrial parasystole has been reported in diseased hearts in the absence of digitalis[4] as well as in normal hearts.[21-23] The presence of atrial parasystole usually does not cause any hemodynamic compromise, although rarely it may do so if the parasystolic rate is very fast or the ectopic rhythm precipitates a faster dysrhythmia.[24] Treatment is not generally indicated except for alleviation of any accompanying symptoms such as palpitations, when therapeutic intervention is not different from that of non-parasystolic atrial ectopic beats. The presence of this dysrhythmia does not suggest a poor prognosis. This depends on the underlying disease, if any.

SUMMARY

Atrial parasystole is characterized by the presence of an ectopic atrial pacemaker which competes with the dominant rhythm and demonstrates a unique unidirectional protection block. It can be recognized by the presence of atrial premature complexes bearing inconstant coupling intervals, but with inter-ectopic intervals that are equal or bear a simple numerical relationship to one another (due to the presence of an exit block). Rarely, fusion beats may result. Differential diagnosis includes atrial ectopics not occurring in a parasystolic fashion, atrial dissociation and artifacts. Its presence is not associated with any particular disease entity and does not prognosticate a dismal clinical course. Since it is usually benign, therapeutic intervention is not generally indicated.

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THERAPEUTIC DRUG INFORMATION

This information is compiled by the Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Arnold and Marie Schwartz College of Pharmacy and Health Sciences, Long Island University.*

1. Recently, shampoos and other jojoba oil products have been advertised to the public. Does jojoba have a medicinal value?

The jojoba (pronounced "hohoba") shrub (Simmondsia Chinesis), native to arid regions of southwestern North America, is being cultivated now in other countries including Israel.[1,2] Its seeds contain a liquid wax (jojoba oil) with properties similar to sperm whale oil. The product is reported to be remarkably stable against heat, ultraviolet rays and rancidity.[3]

Jojoba oil has been used successfully as a permanent lubrication for pacemakers, and a valuable media in which penicillins and cephalosporins can be grown. [3,4] It also has been suggested as a base for the inclusion of medication in the treatment of acne.[5] In addition, several cosmetic companies now market jojoba oil and jojoba-base products. The most frequent claim made is that the products improve hair growth.[6] No scientific studies could be uncovered to back this claim.

Standard toxicity tests in laboratory animals indicated that it did not produce significant irritation to eyes of rabbits, pathological inflammations, nor did it have acute toxicity in mice.[3] Except for patients with skin disorders who are inherently hyperallergic to cosmetic base oils, jojoba oil can be considered safe for human skin.

In conclusion, jojoba oil appears to provide a useful replacement for sperm whale oil, the importation of which is banned by the United States.[1] Its therapeutic properties yet have to be substantiated.

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2. Could you supply information on the use of 2-deoxy-d-glucose in the treatment of human genital herpes infection?

Genital herpes simplex infection accounts for approximately 13 percent of all venereal disease in the United States, and presently there is no effective approved treatment for it. [1] This infection may be related to cancer of the cervix and can infect the fetus at the time of birth.[2,3] Various studies suggested that 2-deoxy-d-glucose, an analogue of glucose, may be an effective agent for the treatment of this condition.[1,4,5]

Courtney *et al.*,[4] in 1973, demonstrated *in vitro* that 2-deoxy-d-glucose produced a 99 percent inhibitory effect on the maturation of an enveloped herpes simplex-1 virus. Gallaner *et al.*[6], utilizing cell cultures, demonstrated the ability of 2-deoxy-d-glucose to inhibit cytopathological changes resulting from infection of herpes simplex-1 virus.

Blough and Giuntoli,[1] in a double-blind, controlled study evaluated the effects of 2-deoxy-d-glucose on genital herpes infections in 36 females. A O.19 percent gel of 2-deoxy-d-glucose in miconazole nitrite 2 percent cream was applied topically and intravaginally twice daily. Miconazole cream (sold as Monistat®) alone, or with dextrose, was used as a control. Ninety percent of the 2-deoxy-d-glucose-treated patients were asymptomatic within four days of treatment compared to 15 days in the control group. Duration of lesions was about eight days in the 2-deoxy-d-glucose-treated group compared to approximately 18 days in the control treatment groups. The duration of positive viral cultures was about four days in the 2-deoxy-d-glucose treated group compared to 15 days in the controls.

In conclusion, the use of 2-deoxy-d-glucose may provide an effective chemotherapeutic agent in the treatment of genital herpes virus infections, but further studies are needed to confirm this.

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*The Center serves as a source of intelligence on therapeutic and pharmaceutic information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists: Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Arnold and Marie Schwartz College of Pharmacy and Health Sciences, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 5 p.m.—telephone (212) 622-8989 or 330-2735. Responses to these questions were prepared by J.M. Rosenberg, Ph.D., Pharm. D.; P. Sangkachand, M.S., R. Ph.; H. Boothe, B.S. Pharm.

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3. What is the proper dose of dipyridamole for antiplatelet activity?

Dipyridamole (sold as Persantine®) is a coronary vasodilator indicated for the long-term treatment of angina pectoris. It is used investigationally to decrease platelet aggregation in a number of thromboembolic diseases.[1] The drug presumably, by a poorly understood mechanism, retards the formation or growth of an arterial lesion by interfering with platelet accretion at a site of vascular injury. Little data are available to assess the clinical value of dipyridamole's antiplatelet activity.

Genton *et al.*,[2] in a review of use of platelet-inhibiting drugs for prevention of clinical thrombotic diseases, indicated that dipyridamole appeared ineffective in cerebrovascular disease and of no appreciable benefit in venous thrombolism. In patients with prosthetic heart valves, dipyridamole in combination with warfarin (sold as Coumadin®), was more effective than warfarin alone in reducing the incidence of systemic embolism.

Sullivan *et al.*,[3] in a long-term controlled study of 163 patients who survived prosthetic cardiac-valve replacement, compared the incidence of arterial emboli in those who received 400 mg daily of dipyridamole or placebo. Arterial emboli occurred at a significantly higher frequency in the placebo-treated group compared to the dipyridamole-treated group.

Browse and Hall,[4] in a double-blind clinical trial involving 649 postsurgical patients, found that 400 mg dipyridamole daily reduced platelet adhesiveness but did not affect the incidence of deep vein thrombosis.

Wilding and Flute[5] reported that two patients with peripheral vascular occlusion of the arm who did not respond to anticoagulants improved when given 400 mg dipyridamole daily for six weeks and three months, respectively.

Dale *et al.*,[5] in a crossover design, studied the effects of daily doses of 375 mg dipyridamole alone, two grams of aspirin alone, and the combination of one gram of aspirin and 25 mg of dipyridamole on platelet function of five patients with prosthetic ball valves. Dipyridamole alone did not cause significant change in any parameter of platelet function while aspirin did. Similar effects were obtained with the combination of the dipyridamole and aspirin as with aspirin alone.

Renney *et al.*[7] conducted a controlled study in 160 patients utilizing a combination of dipyridamole and aspirin to prevent postoperative deep vein thrombosis. Eighty-five patients in the treatment group received one gram of calcium aspirin and 100 mg dipyridamole by mouth on the evening before operation and for seven days after surgery or until discharged from the hospital. The remaining patients served as controls. The investigators found that 24 patients in the control group developed thrombosis, compared to 12 in the treatment group. The difference is significant.

Frequent side effects associated with the high doses of dipyridamole included nausea, vomiting, vasodilation and vascular headache.[2,4,8]

In conclusion, some studies indicated that high doses of dipyridamole (400 mg daily) may reduce platelet adhesiveness but others do not. The clinical significance of this has not been determined fully and requires further studies.

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YOUR CONGRESSMAN SPEAKS

Communication with Congress

THE HONORABLE HAROLD C. HOLLENBECK, Washington, D.C.*

No profession has made a greater contribution to the well-being of Americans, nor will determine to a larger degree what kind of a country we will be in the years ahead, than the medical profession. During a period of time when this nation is facing enormously technical and difficult decisions for which there are no easy solutions, it is imperative that physicans and legislators not lose the art of talking to one another. In this interest, I am appreciative of this opportunity to offer observations from my vantage point in the Congress.

It is not uncommon for members of professional societies, and members of the business community, trade associations and other interest groups, to excuse themselves from involvement in the political process on the grounds that they "don't know much about politics"—as if the practice of politics is akin to some form of black magic. Our institutions are large, and thus disorderly and of a diverse nature. We are dealing with big government, big business, and big labor, and it is certainly true that we live in a difficult and complex world.

I feel, however, that politics and the political process are not inherently complicated. I want to suggest that participation in the legislative process involves only two major components; identification of the key members in the process of consideration, and presentation, from a local base if possible, of reasonable, factual arguments relating to their interest, as well as to your own.

In part, communication becomes a problem, not because we do not know what we are talking about, nor because we are not speaking clearly, but because, very often, we simply do not know with whom to talk. The common theme of American political thought and reform in recent years has been the division and distribution of power. Various members assume leadership roles. From issue to issue, from bill to bill, and from Congress to Congress, that leadership naturally shifts.

For example, the House Committees on Interstate and Foreign Commerce and Ways and Means shared jurisdiction over the hospital cost-containment legislation considered by the full House of Representatives last year. The final version enacted by the House, which I supported, was a substitute to the versions reported after Committee deliberations offered by Congressman Richard Gephardt. The issue of a national health insurance program, one that has been debated in Congress for many years, is the subject of consideration in four separate bills pending at committee level; two in the House and two in the Senate.

In my committee assignments, as well, health care issues have been the focus of attention. The recent forum I held on "Health Care for the Elderly" in Fort Lee came in conjunction with Select Committee on Aging efforts to gather information from across the country on the health needs of older Americans. Medicare coverage was a major topic of concern, as a number of Medicare amendments, including an expansion of home health benefits, have been approved at the committee level in this Congress.

Last summer, as ranking member of the House Science, Research and Technology Subcommittee, I was instrumental in organizing hearings on the transfer of space technology to new medical applications. Some of the applications which have been implemented to date have met with great success. For example, the lixoscope, used by astronomers to detect x-ray images from stars led to the development of compact x-ray equipment which can be brought to the homes of bedridden and handicapped patients. Its radiation intensity is much lower than that emitted by more traditional equipment.

One bill now under consideration by the House Science and Technology Committee would help ensure that defense technologies with second-level medical and scientific applications be made available for private sector use.

Because of this diversity and disbursement of leadership roles, it is the job of your local representative to put you in touch with the right member on the right issue at the right time. Your representative also should assist you in making your views known and help provide you with the appropriate background information you will need to do so. In many instances, the member, himself, will have the opportunity to offer direction and to promote proposals on legislation in which you have an interest. Legislation is a long and slow process—too long and too slow, many contend—but at each of the various stages of introduction, referral, committee hearings, mark-up, committee reports and floor action, there is a remarkable opportunity to make contributions. The final vote is the last step in the process, not the place to start.

Let me emphasize, as well, that the agenda of public business need not be left to dealing with problems that have

*Congressman from the 9th District; member, Committee on Science and Technology and its Subcommittees on Science, Research and Technology (Minority Leader), Energy, Research and Production; Committee on Standards of Official Conduct; Select Committee on Aging and its Subcommittee on Health and Long-Term Care. He may be addressed at 1526 Longworth House Office Building, Washington, D.C. 20515.

grown to the ugly size of a crisis. Affirmative proposals amending laws that do not work, or suggesting changes that will help your profession or seek alternative solutions to concerns are most welcome and productive. In view of the myriad contributions the medical profession makes each day to the quality of American life, there is certainly no reason to work from a defensive position.

Presentation is the second key. Congress is more responsive to public attitudes than many can believe. Yet, for several years now, I have attended committee hearings and listened to witnesses for interest groups, including business and professional societies, who talk at great length about how a particular measure would affect their interest, but who never identify how that interest coincides with the national interest.

Most members of Congress genuinely try to promote what they feel is in the best public interest from their parochial point of view. Each is acting upon national legislation, but measuring bills by what they will do in his own district. When there is a conflict between a partisan position and a local interest, partisanship usually does not stand a chance. Local interests determine in a fundamental way what committee members seek, what legislation they introduce, and how they vote. If we did not listen to the people we represent, we would not be representing them very long.

In this era of information explosion, members of Congress and members of the medical profession spend the greater portion of their time under rather harried conditions. While I will not attempt to elaborate on the demands of my schedule to the readers who have followed my thoughts thus far, I will offer a few examples of what generally has been determined by my colleagues to be ineffective and effective approaches to dealing with legislators who always have twice as many items on their schedules as hours in the day.

The **ineffective** communication:

The Complainer—He only contacts the Congressman to complain about a vote, or a bad bill, or about the general condition of things, without offering something better.

The Demander—He thinks that anyone with a reasonable degree of honesty and intelligence should be able to reach the same conclusion that he has.

The Last-Minute Telegram Sender—His message is waiting for you when you get back from the vote.

The Post-Card Brigade—These are the first cousins to the Demanders. They sign their names to someone else's opinion and expect personalized responses.

The Bore—He expects a thirty-minute appointment to advise that there might be something coming up later in the year he will want to talk about.

The **effective** approach:

Members of Congress always appreciate a brief presentation, indicating the impact of an issue on your profession and on the general public, especially that peculiar to local interest. Do not always expect an immediate position statement from the member at the conclusion of the presentation. Just as physicians cannot make an immediate diagnosis without all of the facts, legislators may need to research aspects of proposals with which they are not completely familiar. Keep in touch with other interest groups to know your opposition and what other supporters are planning. If the member does vote your way on an amendment or a bill, be prepared to give him back-up support.

Your political action committee and your spokespeople in Washington are doing a fine job in representing the legitimate concerns of one of our nation's most dedicated and qualified groups of professionals. It has been my privilege to work with them. Whenever I might be of help in your individual or collective efforts, please let me know.

DOCTOR'S NOTEBOOK

Trustees' Minutes July 13, 1980

A regular meeting of the Board of Trustees was held on Sunday, July 13, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Cancer Control Committee . . . Postponed further consideration on the activities of the Cancer Control Committee pending discussion between Dr. Baker and the Executive Committee.

Note: As a result of the Board's directive (May 13, 1980) for establishment of a more responsive committee, the membership has been expanded, a new chairman has been appointed, and a suggestion has been made that perhaps a liaison should be established with groups actively involved in cancer education and research, rather than maintaining the committee format.

Medicaid Fee Pilot Program . . . Noted that a pilot project is being developed in three New Jersey counties to determine the overall effect on the state and federal governments, on hospitals, and on the medical profession of compensating primary care physicians on the usual, customary, and reasonable fee basis when treating Medicaid patients in an ambulatory setting.

Reinstatement Policy for Dues Delinquent Members . . . Accepted the following as current reinstatement policy for delinquent members:

1. June 1 through December 31—payment of the annual dues owed plus $50 reinstatement fee.
2. After December 31—payment of full dues of the current year plus one year of the delinquency.

Implementation of this reinstatement policy will be effective in 1981.

Medicare Reimbursement to Hospital-Based Physicians . . . Noted that in response to action of the Board on May 13, a communication has been sent to the Health Care Financing Administration questioning its action in reaffirming the principle that a service furnished by the physician to the entitled hospital patient is to be reimbursed on a reasonable charge basis under Part B only if it is an identifiable service to the patient that requires performance by a physician in person and contributes to the diagnosis and treatment of the patient. All other covered services will be reimbursed to the hospital.

Note: The matter has been brought to the Board's attention by the New Jersey Society of Pathologists, and there is concern also of the professional role of the anesthesiologists, radiologists, and others.

Standards for Telephone Directory Listings . . . Received the following standards for listings in telephone directories as determined by the State Board of Medical Examiners, based on interpretation of N.J.A.C. 13:35-6.13.

1. Telephone listings in both white pages and yellow pages shall be limited to printed text only, with no pictorial displays of any kind. There shall be no black border or other form of set-off background in either white-page or yellow-page listings.
2. Printed matter in the white pages shall be uniform in size with all other page listings, and may be in regular type or bold type.
3. Printed matter in the yellow pages or in any type of classified directory of professional licensees shall be in regular type only and shall be uniform in size with all other page listings.
4. In the yellow pages there shall be one alphabetical listing for physicians licensed to practice medicine and surgery, entitled "Physicians and Surgeons." That list shall include doctors of medicine and doctors of osteopathy. The name of each licensee shall be followed by the academic degree earned. The list may include professional groups and associations.
5. There shall be an entirely separate alphabetical listing for chiropractors, doctors of podiatric medicine, midwives, and any other category of licensee with a limited right to practice medicine.
6. Specialty listings shall include both doctors of medicine and doctors of osteopathic medicine within each specialty heading or caption. The name of each licensee shall be followed by the academic degree earned. Professional groups or associations may be included within specialty listings.
7. Within the separate listing for doctors of podiatric medicine, podiatrists may have separate specialty headings if desired.
8. The number of specialties in which physicians of plenary license or limited license may list themselves is not limited, provided that such listings are not false or misleading. The truthfulness of the listing is the responsibility of the licensee.
9. There shall be one specialty combination heading of obstetrics and gynecology. However, a listing within that specialty heading may state that the practice is limited to one or the other.
10. The number of separate directories in which physicians may request listings is not limited.
11. Educational information services, such as pre-recorded tapes, shall be shown in the anchor listing under the name of the service, but the display shall include the name and academic degree of the individual sponsor, except in the case of an institutional or professional society sponsor which shall be listed as such. Such educational information services shall not be included within the alphabetical or specialty listings of licensed practitioners, but shall be a separate listing of health information services.

Note: MSNJ has been invited to be represented at a meeting of the State Board and New Jersey Bell on August 27 concerning this matter.

Conference on Impaired Physicians . . . Authorized the attendance of four representatives from the Committee on Impaired Physicians at the AMA Fourth National Conference on Impaired Physicians on October 29 to November 1 in Baltimore.

Membership Data . . . Noted that MSNJ paid membership as of June 30 was 7,430, up 46 from the previous month, and of that number, 4,424 are members of the AMA.

Litigation Update—

1. Livingston vs. MSP, MSNJ, et al . . . Noted that the court has been informed that the Society will not abide by any further adjournments and will argue this case at the next scheduled motion.

2. State Board of Medical Examiners vs. Driggs . . . Noted that litigation is being pursued in the Appellate Division and a preliminary injunction was issued this

week against the State Board that revocation of Dr. Driggs' license and penalties could not take effect until a final hearing is held in the Appellate Division.

3. **Supreme Court Subpanels** . . . Agreed that the Society should not enter into litigation, as nothing would be gained by intervention, concerning an Appellate Division ruling involving Rule 4:21—Supreme Court Subpanels—that a physician who has an active suit against him may not sit on a Rule 4:21 panel while his suit is being appealed to the State Supreme Court.

Radiological Services Regulation of the State Board of Medical Examiners . . . Agreed to the Society's involvement in pending litigation to oppose the State Board of Medical Examiners' ruling that it is a violation of the Medical Practice Act for a physician providing radiologic services to discriminate against a request from a chiropractor for these services on the basis of license classification.

1981 Annual Meeting . . . Approved a recommendation to hold the 215th Annual Meeting, MSNJ, at the Meadowlands Hilton, Secaucus, May 16 through May 19, 1981.

. . . Approved a recommendation that the 1982 Annual Meeting be held at Resorts International, Atlantic City, May 14 through May 17, 1982.

. . . Referrred the following proposed agenda schedule back to the Annual Meeting Committee with the request that they explore the suggestion of having reference committee meetings at MSNJ headquarters, with an open invitation to the membership, two weeks in advance of the Annual Meeting.

1. Check in at hotel on Friday evening (or Thursday);
2. Schedule first meeting of the House for 9 a.m. on Saturday (or Friday);
3. Adjourn the House mid-morning on Saturday (Friday); reconvene for election session; adjourn and schedule all reference committee meetings for that afternoon;
4. Schedule all scientific sessions for Sunday (or Saturday);
5. Schedule the House to consider reference committee reports at 9 a.m. Monday (or Sunday) and continue all day, thereby eliminating one day.

. . . Approved a recommendation that the section officers be urged to use New Jersey speakers and be limited to one out-of-state speaker per session (advance approval of the Committee on Annual Meeting will be required for more than one out-of-state speaker).

Medical Education . . . Agreed to table discussion, until after the AMA meeting (July 20-24), on a recommendation of the Committee on Medical Education that MSNJ advocate the position taken by the American Society of Internal Medicine on future directions for medical education.

Impaired Physicians—Executive Coordinator . . . Referred back to the Committee on Impaired Physicians a request for full-time executive coordinator and an administrative assistant for the Committee and directed that a job description be developed as part of the proposal.

State Board of Medical Examiners . . . approved a recommendation that MSNJ's Board of Trustees invite a member of the State Board of Medical Examiners to attend the monthly meetings of the Board.

Medicolegal Education Programs . . . Acknowledged the fine accomplishments of the Department of Liability Control in developing programs on medicolegal problems which have been directed appropriately toward specialty societies. The Board feels that a program to teach general practitioners, medical students, and residents basic medicolegal facts and how they interrelate with the court system should be developed. It was suggested that possibly the Academy of Medicine could structure such a program with a hospital-based education program concept.

Physician Assistant Legislation . . . Noted that the changes in the bill (NJ Legislature) concerning physician assistants are insignificant in respect to MSNJ's objections and that the Society still is opposing the legislation.

Members Insured Through State Reinsurance Association . . . Directed that an appropriate response be made by the Executive Director and the President to communications received concerning representation before the Insurance Commissioner of members of MSNJ who are insured by the State Reinsurance Association rather than by the Medical Inter-Insurance Exchange of New Jersey. The Board is sympathetic to the concerns of these members, and the Society has and will continue to represent their interests but is not in a position to exert the type of influence that can be employed with the MIIE.

Physical Therapists Accepting Orders from Podiatrists . . . Authorized MSNJ Legal Counsel to proceed with investigation of a matter concerning the legal opinion obtained by the State Board of Medical Examiners, based on the fact that a podiatrist is a physician, that now a physiotherapist can accept orders and direction from a podiatrist for physiotherapy treatments.

Note: N.J.S.A. 45:9-37.7 was repealed, effective February 14, 1980. Part of this section indicated that physical therapists could take direction only from a licensed physician. Research of the legal literature does not reveal the existence of a formal opinion filed by the Attorney General, and the procedure utilized by the State Board in reaching its conclusion is questioned.

Resolutions—MSNJ Annual Meeting, 1980

Extend an Invitation to the State Board of Medical Examiners to Deliver a Report at MSNJ's Annual Meeting—Resolution #18 . . . Noted that the State Board of Medical Examiners has accepted the invitation and authorized the President of the Board or his representative to make the presentation.

Countersigning of Medical Orders—Resolution #20 . . . Voted to resubmit the resolution in question to the State Board of Medical Examiners as it was felt there apparently was a misinterpretation on the part of the State Board. The Board had reaffirmed its present position on the countersigning of orders and prescriptions of unlicensed physicians and determined that there was no current legislative authority that would permit medical students to write orders, as only interns and residents are exempted from the licensing provisions of N.J.A.C. 13:35-6.10.

Note: The intent of the resolution was to convey the Society's position that educational purposes are being served by having students write orders and prescriptions with the physician signing as if they were his own, thus there would be no effect until the order was signed by the attending physician.

Undergraduate Clinical Training of Foreign Medical Graduates—Resolution #24 . . . Noted that the State Board of Medical Examiners had made an interim ruling to permit foreign medical students

currently serving in the 7th and 8th semester clinical training programs in hospitals in New Jersey, previously approved by the State Board of Medical Examiners, to complete the program that will terminate in December 1980. No new programs can be started until the Board and the Department of Higher Education resolve questions concerning future approval of hospitals for 7th and 8th semester programs.

Cessation of Sludge Dumping—Resolution #15 . . . Noted that the United States Environmental Protection Agency has responded to this resolution indicating that it consistently has enforced the 1981 deadline against municipalities' ocean dumping sewage sludge. Over the past two years 15 municipalities have phased out this procedure and the remaining 20 have been notified that they must comply by December 31, 1981. However, the New Jersey Department of Environmental Protection is unable to consider support of complete cessation of ocean dumping of sludge after 1981 at the cost of other serious detrimental effects on New Jersey's environment. The 106-mile site is felt to be the appropriate location of this activity until environmentally sound land-based alternatives can be developed.

Request for Full Disclosure of Chemical Dump Explosion in Elizabeth—Resolution #22 . . . Noted that the federal Environmental Protection Agency is serving as a central clearinghouse for all scientific information and data on the chemical dump explosion in Elizabeth. The EPA will release a report containing all data taken at Chemical Control with annotations designating their significance, and a copy of the report will be forwarded to the Society upon its release (see letter from Governor Byrne, page 611, *Journal,* MSNJ, August 1980).

Update Physicians' Fees for Services to Medicaid Patients—Resolution #6 . . . Noted an acknowledgement from the Commissioner of Human Services concerning this resolution which stated that her requests for additional funds to upgrade reimbursements to physicians who provide services to Medicaid patients have been unsuccessful.

Standards for Health Insurance Coverage and Federal Subsidy of Health Maintenance Organizations—Resolutions #4 and #11 . . . Noted that response had been received from Congresswoman Millicent Fenwick stating that the maximum use of existing health programs should be encouraged and that on the subject of HMOs she believes that an approach which has maintained quality care and assisted in keeping prices down should not be discouraged; and that catastrophic health insurance should be the first priority (see letter from Congresswoman Fenwick, page 611, *Journal,* MSNJ, August 1980).

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

Some of you may have read or heard about a series of five articles recently published in the *Star-Ledger* on CMDNJ's College Hospital. The articles, by and large, presented a distorted picture of College Hospital, and contained serious errors of fact. CMDNJ has taken several steps to correct the record, one of which is the submission of a Letter to the Editor of the *Star-Ledger.* In this letter, which appears below, we have attempted to address the major inaccuracies and issues raised by the articles.

July 21, 1980

To the Editor of the *Star-Ledger:*

This letter is in response to the series of articles published June 29-July 3, 1980 pertaining to the College Hospital of the College of Medicine and Dentistry of New Jersey (CMDNJ). Our general concern is that the thrust of these articles presents an inaccurate picture of the CMDNJ-College Hospital.

CMDNJ cooperated fully with the *Star-Ledger* during the investigation of the series of articles and provided the reporters with detailed information in response to their numerous questions. CMDNJ's policy is one of openness in these matters. Not only do we offer to the press complete access to information, but under the policy of the CMDNJ Board of Trustees and the administration, all issues and problems facing the College or one of its components are discussed publicly and candidly at the monthly meetings of the Board.

Yet, in spite of the availability of the material, the series presented a profile of the Hospital which was both inaccurate and slanted. Not only were there grave errors made on specific points of information (of which I will cite examples later), but there also seemed to be a basic misunderstanding of the hospital's history and philosophy.

The reporters challenged the concept of a hospital with a dual role—its origins, its purpose and its ability to fulfill both functions. The series conveys the notion that an institution with primary and tertiary care responsibilities was ill-conceived, and the concept adopted merely to justify the construction of College Hospital. This is not true. In reality, the mission of CMDNJ and of its primary teaching facility in Newark was carefully considered over more than a decade, by State and Federal officials, by health care professionals and by community leaders. Its role was openly debated in many forums, and altered or enhanced as deemed appropriate. Your reporters' omission of these developments, which have been heavily reported in your own publication over the years, is inexcusable.

The idea of a College teaching hospital as a center for tertiary care—the scarce and highly advanced services which are beyond the resources of most community facilities—dates back to the mid-'60s, and is based on New Jersey's needs. Since the State had no program in medical education for two hundred years, many specialized services did not exist anywhere in New Jersey, and therefore we lacked the ability to attract a broad spectrum of professionals to deliver this type of care. It was primarily to remedy this situation that New Jersey acquired its own medical school in 1964, through the purchase of the Seton Hall College of Medicine and Dentistry. The state's commitment to medical education was endorsed by Governor Hughes, as he signed the bill by which the Seton Hall complex was acquired, and by Governor Cahill, when he supported the creation of CMDNJ in 1970, as well as by the State Legislature which approved both acts.

The concept of the teaching hospital as a provider of primary care emerged in the late '60s and was a revolutionary idea for its time. Never before had a medical school deliberately relocated to an impoverished, inner-city area, and never before had an institution of learning agreed to take an active role in the health care delivery system. The decision was a bold one, dictated by the times and by the dire needs of the Newark community.

The historic Newark Agreements of 1968, which formalized the medical school's role in the community, was a

landmark in medical education, providing a model which many other institutions have since emulated. Neither the school nor the hospital had any part in the negotiating sessions which resulted in these agreements. We merely accepted the wisdom of a committee which consisted of community leaders, State officials including the Chancellor of Higher Education, and representatives of the U.S. Departments of Health, Education and Welfare and Housing and Urban Development.

From the College's inception, its teaching hospital in Newark, first Martland Medical Center and now College Hospital, has provided both primary and tertiary care. Although development of certain sophisticated programs had to be postponed until the new hospital could be built, which the obsolescent Martland was not designed to accommodate, important strides were made throughout the decade that Martland served as teaching facility to the Newark campus.

Primary care was the first priority during CMDNJ's early years, since the community's health needs were so desperate. Outpatient services were expanded and improved, culminating in the opening of a spacious, modern Family Health Care Center in 1974. Psychiatric outpatient and emergency units, a family planning clinic, and an alcoholism unit were established. In addition, special prevention and screening projects were initiated under Federal or State funding, to help reverse some of the area's most serious health problems. These included hypertension and heart attack prevention, childhood lead poisoning, pre-natal care for high risk mothers, patient education, and alcoholism and drug abuse programs.

The impact of the medical school and its services to the community is validated by the dramatic reversal in health statistics which took place during that first ten years, including a 50 percent decrease in infant mortality, a 60 percent reduction in tuberculosis deaths, a 50 percent decrease in the cancer death rate, as well as significant drops in deaths due to bronchial pneumonia and heart disease. We are proud to have had a role in these improvements, and we continue to strive for an even higher standard of care.

In the concluding article, the *Star-Ledger* touched upon some of these accomplishments. College Hospital, which opened its doors in January, 1979, is a sharp contrast to the Martland, with its ultra-modern physical plant and the latest in diagnostic and other equipment essential to a first-class hospital today. Within nine months after it opened, College Hospital received the maximum two-year accreditation from the Joint Commission on Accreditation of Hospitals, the national agency which sets standards for institutions of health care.

Symbolic of its progress is the fact that College Hospital was one of only 15 teaching facilities throughout the country to receive a grant from the Robert Wood Johnson Foundation in a pioneering program to enhance continuous, personalized treatment in outpatient clinics. Awarded in April, 1980, the $800,000 grant will assist in converting the hospital's ambulatory care services to a physician group practice system, in which patients can receive comprehensive primary care and specialty referrals under the supervision of a single physician.

Equally important are the number of "only" services in the state offered by the hospital. It has the only multiple sclerosis clinic, and the most sophisticated equipment for diagnosis and treatment of many diseases, including the only facility capable of electrodiagnosis for sleep disorders, and a new test to identify muscular dystrophy in children. Within the next few years College Hospital will have the most advanced cancer research and treatment center in the State.

In the Hospital's Department of Obstetrics and Gynecology, services such as genetic screening and amniocentesis tests, as well as the latest technological developments—including continuous electronic fetal monitoring, ultrasound diagnosis and fully equipped rooms for cesarean section—are available to all pregnant women. In conjunction with heightened emphasis on family-centered childbirth, separate classes for new mothers and new fathers are offered along with classes in natural childbirth and maternal nutrition. A "birthing room" designed to resemble a home bedroom for medically selected cases is also on the premises for those who prefer this natural environment.

Through its emergency department, College Hospital and its predecessor have completely reversed the statistics on survival of patients with traumatic injury to the heart. Ten years ago only 20 percent of these patients survived; today only 20 percent are lost. The emergency department offers full-time, round-the-clock coverage by attending physicians, a factor which can mean the difference between life and death to those with serious injury. In addition College Hospital has been designated as the facility which receives emergency cases through the State Police MEDEVAC System, dispatched through the Regional Emergency Medical Communications Service of CMDNJ.

Our physicians, too, are making frequent and significant contributions in the field of medical and surgical research and knowledge. The presence of physicians in various specialties at College Hospital permits a multidisciplinary approach to the improvement or cure of illness and disability. The effectiveness of this approach was evidenced a few weeks ago when a team of surgeons performed successful brain surgery to repair a dilated blood vessel on the brain of a 16-year old girl. This surgery required both a team of neurosurgeons to repair the blood vessel and a team of cardiac surgeons to stop the heart while the brain surgery was performed.

The performance of College Hospital as a teaching facility is reflected in the high scores consistently achieved by CMDNJ students on examinations given by the National Board of Medical Examiners. Students in their third and fourth years at CMDNJ-New Jersey Medical School take a major portion of their clinical training at College Hospital. In this year's graduating class, for instance, one student scored above the "highest possible" score of 800. Two other students achieved scores above 800, and the class as a whole scored 23 points above the national average of 500.

We are proud of these and other accomplishments, and we will continue to pursue vigorously our goal of providing New Jersey and Newark with high quality primary care and designated tertiary health services. However, despite significant progress, a medical center's reputation is not built overnight and an institution open only 18 months cannot be expected to compete in reputation and referrals with some of the nearby medical centers which have developed over many decades.

Our efforts to establish a reputation are further hampered, however, when unsubstantiated rumors and proven inaccuracies are printed as fact by a newspaper. Granted, the last two parts of the series were generally positive, and took note of the significant accomplishments and successes achieved by the Hospital in spite of many external pressures under which it must operate. However, the first three articles were biased and unfair, both in the nature of the subject matter

and the manner in which the material was presented.

To cite some specific examples:

1. Hiring Practices—The labeling of our hiring practices as "arbitrary" and based on "cronyism" is unwarranted and erroneous. As a State institution, CMDNJ has strict and clearly delineated policies and procedures governing fair employment practices, recruitment activities, employment processing and the classification of all College employees. For these reasons, "cronyism"—giving preferential treatment to acquaintances without regard to qualifications—cannot exist at CMDNJ.

This characterization of CMDNJ's hiring practices is unfair for two reasons. One, several persons named in the article as victims of "cronyism" actually were requested to resign because of longstanding dissatisfaction with their performance. Two, all recruitment and employment at CMDNJ is conducted according to strict guidelines and policies which conform to all state and federal regulations governing personnel activities.

In order to establish a new position or reevaluate an existing one, a CMDNJ department head must submit a request to the Position Management branch of Personnel for development of a formal job description. This description outlines the duties and responsibilities of the position, along with any necessary educational or training requirements, and is based on comparative job titles in other institutions and State government. The job description then receives two additional levels of review, with final approval by a committee consisting of the Executive Vice President, the Vice President for Finance and the Vice President for Personnel. A description of the new position is then forwarded to the New Jersey Department of Civil Service.

Full responsibility for recruitment and employment processing lies with the CMDNJ Employment Office. The position is posted internally first, to provide current employees with promotional opportunities. If no qualified candidates emerge, outside applicants are sought through advertising and other means. The Employment Office screens all internal bids and external applications, and sends letters of rejection to those who do not meet the established criteria for the position.

All qualified applicants are referred to the hiring department head. Internal candidates must be interviewed, and the results of all interviews must be forwarded to the Employment Office in writing. When a candidate is selected by the department head, the applicant's qualifications, along with his references, are again checked by Personnel.

Throughout the recruitment and hiring process the CMDNJ Affirmative Action Office participates to assure that every attempt is made to identify qualified minority applicants.

The *Ledger's* allegation that CMDNJ-College Hospital has experienced a 45 percent turnover in administrative staff is untrue and misleading. Since the College Hospital opened in January 1979, the following turnover among management personnel has occurred: Of a total of 12 administrative staff members, five resigned (three for better positions, two whose resignations were requested), one was transferred to another position at CMDNJ, and one retired. Of 26 department heads, four resigned (three for better positions and one whose resignation was requested), one transferred to another College position, and one took maternity leave. Such turnover could be expected in any institution.

2. State Health Department Citations—Allegations are made without any attempt to place them in perspective for the reader by drawing comparisons with other hospitals. Hospitals are complex institutions, and most experience similar problems, particularly those in urban areas. Therefore, to present a balanced viewpoint, a distinction must be drawn between problems generally encountered by all and those unique to College Hospital.

For instance, much space was devoted to a discussion of the citations from the State Department of Health for housekeeping and medical records. The *Ledger* failed to point out that it is not unusual for hospitals to be cited for housekeeping problems and that the particular citations discussed in the *Ledger* were rendered following an inspection made nine days after the hospital opened in January, 1979, after an extraordinarily successful move.

As for medical records, the *Ledger* failed to present comparative information given to the reporters which revealed that the medical records' backlog at neighboring hospitals ranged from 1,000 to 2,500 charts outstanding as compared to College Hospital's then 1,500 outstanding charts. Although the problem is not as serious as presented, the CMDNJ-Board of Trustees and the Hospital Administration recently took steps to reduce the number of outstanding charts.

3. Professional Services—Significant discussion in the articles centered around the quantity and quality of the professional services delivered at the institution. Several problems arise relative to the credibility of information presented on this issue. For instance, only one of the nine department chairmen responsible for clinical services in the Hospital was contacted by the *Ledger,* and this contact was superficial in nature.

Yet, serious allegations were made about the quality of several professional services at College Hospital. The articles stated that attending physicians were frequently unavailable to carry out their patient care functions. In fact, College Hospital is the only hospital in the state to require several attending physicians to sleep on the premises each night in order to be available to take care of emergencies. At most hospitals, attending physicians are available by telephone. College Hospital offers the additional coverage of an average of ten attending physicians and 41 residents (post-graduate physicians) on the premises each night. The Departments of Medicine, Anesthesiology and General Surgery each require an attending physician on duty, and others represent various subspecialties.

In addition, the articles stated that 39 physicians resigned from the hospital staff as of June 30, 1980, creating the impression that a mass exodus of physicians occurred as a result of the problems of the hospital. Nothing could be further from the truth. The reporters were explicitly told that resignations from the medical staff occur as part of the normal annual reappointment process which requires that attending physicians update their credentials. This year, of the 600 attending physicians at College Hospital, 17 resigned and 64 were not reappointed. The majority of these were voluntary, unpaid faculty who were dropped for failure to serve the requisite number of hours in the Hospital clinics to enable them to retain attending status, or because they indicated lack of time or interest.

4. Medical Issues—Several incidents related to health care delivery were reported inaccurately by the *Ledger.* These errors were most distressing to us, since they misrepresent the quality of patient care at College Hospital.

One such case involved a coagulase positive staphylococcus (staph) infection which occurred in the newborn nursery in February, 1980. The *Ledger* erroneously claimed that two infants died as a result. This is not true. Their deaths

were caused by other serious congenital health problems and were unrelated to these infections. Outbreaks of infection occur in hospitals from time to time. In this case, we requested a review by the State Department of Health to help us determine the cause of the outbreak. Although the Health Department was unable to pinpoint the reason for the infection, during its review, it commended College Hospital for its infection control procedures.

Another report involved a four-month fetus, declared non-viable (insufficiently developed to live outside of the uterus) by a physician in the CMDNJ-College Hospital Emergency Room. Although the *Ledger* charged that there was some question as to the viability of the fetus, it was never considered alive, and at less than one pound in weight, was well below the international standard for sustaining independent life.

Medical statistics were also misreported or taken out of context. Infant mortality rates for College Hospital—which include babies up to one year old—were compared to perinatal mortality rates—which involve babies who die in the period before, during and immedicately following delivery—at other institutions. In the final article, an attempt to show improvement in infant mortality in Newark utilized figures, allegedly obtained from the city's health department, which were grossly inflated—the total number of infant deaths for the year was carelessly reported as a "per thousand" rate.

5. Planning Issues—Finally, we are confused and mystified by the apparent contradictory position taken by the reporters on two issues. The first concerns questioning the need for the construction of College Hospital, while endorsing the decision to build a single facility as a replacement for Martland Medical Center in fulfillment of the Newark Agreements of 1968.

The record is clear. The Health and Hospital Planning Council (B Agency) in Newark approved construction of a 500-bed hospital on July 27, 1972 and a certificate of need was received from the State Department of Health on August 15, 1972. In compliance with health planning requirements, CMDNJ submitted a request to modify the certificate of need in September, 1974 because of an increase in cost of construction. All parties concerned were asked by the State to complete the approval process as quickly as possible because construction bid prices received by the State Division of Building and Construction in September 1974 were limited to 60 days validity. Therefore, on October 17, 1974, CMDNJ was notified by the Commissioner of Health that the State Health Planning Council had overwhelmingly approved a modified certificate of need for a 486-bed facility at a cost of $76.6 million. The "pressures" were not of our making, but rather due to normal bid processes, bond market conditions, and actions properly required of State agencies.

The *Star-Ledger* is further reminded that the construction of College Hospital actually reduced beds in the hospital system. Martland Hospital was licensed for 631 beds, and its replacement, College Hospital for 526.

In fact, the CMDNJ administration has avoided added bed construction by the state in Central Jersey (affiliation between CMDNJ and Middlesex General Hospital) and in South Jersey (affiliations between CMDNJ and Cooper Medical Center and the John F. Kennedy Memorial Hospital). Contrary to the *Star-Ledger,* CMDNJ has been a leader in fulfilling agreements with the Newark Community and the federal government, and in saving taxpayer resources by using existing facilities for its clinical medical education programs.

In addition, the claim that CMDNJ is one of only three medical schools to build teaching hospitals in the last few years is completely untrue, as minimal effort and investigation reveals. Harvard University announced the opening of its new facility on July 1st. The University of Michigan, the University of Louisville, the University of Illinois, Duke University, Vanderbilt University, and Thomas Jefferson University have either constructed, or are in the process of constructing, new hospitals, while Wayne State University (Mich.) has constructed 900 new beds through its affiliated hospital system. These facts were ascertained by a few telephone calls and represent a partial list.

The second issue on which the *Star-Ledger* has taken an inconsistent position deals with the role of College Hospital in the community. In 1977, the *Star-Ledger* expressed concern in an Op-Ed page commentary that the still-under-construction hospital would serve more referral patients from the suburbs "riding down Route 280 in their cars" rather than serve Newark residents. Yet, the recent series seemed to imply that College Hospital has devoted most of its energies to serving the Newark community and had failed to fulfill its role as a referral center. The article stated that "outside the immediate Central Ward, in fact, the hospital has trouble attracting clientele." While it is true that College Hospital is still developing as a tertiary care referral center, the hospital has come a long way in effecting its dual mission within its short history despite the negative image inherited from its predecessor institutions.

For these and numerous other reasons, we are concerned about the quality of reporting by the *Star-Ledger* and the resulting negative impact which some of these articles will have by discouraging patients from utilizing the Hospital.

As a young institution still in the process of developing its reputation as a health care facility, College Hospital is particularly vulnerable to biased and one-sided reporting. We sincerely hope that these articles have not seriously impeded the Hospital as it strives to fulfill its difficult missions. This would be unfortunate, both for the people of Newark and New Jersey who need us, and for the many fine physicians and excellent employees whose dedication and diligence contributed to the growth of the Hospital as a quality institution.

(Signed) Stanley S. Bergen, Jr., M.D.
President, CMDNJ

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

The matter of confidentiality is crucial to the effective use of professional peer review. This is the case with all forms of assessment of medical care as conducted by physicians on the work of their colleagues. Deliberations of committees and other bodies involved in such work should not be subject to scrutiny by others. The reasons for maintaining privacy are, or should be, obvious. If a member of a medical audit committee, for example, is aware that his comments on patient management may be made public, he will confine his remarks to generalities. This robs the process of its educational purpose. Identification of possible problems, analysis of discrepancies, and resolution of patterns of care by medical staff educational procedures benefit all concerned. This has been accepted by the profession for generations.

The establishment of PSROs by federal mandate has brought a new focus to this problem. Litigation has been under way in Washington, D.C., for some time on the question of whether PSROs are subject to the Freedom of Information Act (FOIA). If they are, all PSRO deliberations should be public knowledge. The Federal District Court Judge in Washington, D.C., ruled early this year that PSROs are subject to FOIA, since, in the opinion of the judge, they are government agencies. This decision is under appeal. The plaintiff is the Health Research Group, a Ralph Nader organization.

In June of this year, the District Court in Philadelphia ruled that PSROs are *not* agencies of the federal government, and, therefore, are not subject to FOIA. This decision was based on a Supreme Court opinion which said that an organization cannot be considered a Federal agency unless detailed daily supervision by the government is present. This opinion was rendered subsequent to the District of Columbia decision, and it will be used in the appeal in that court.

Obviously, the last word is not on hand. Resolution of this matter is crucial to the quality assurance aspects of PSROs and any other form of professional peer review. The aggregate results of profiles and other studies can be made available, but the deliberative processes by which physicians discuss and review the work of their colleagues should remain confidential. If they are to provide material for "fishing expeditions" by prospective litigants, physician participation will disappear.

Help Wanted: A Statement on the 1980 House of Delegates

(This statement was submitted by Frank J. Primich, M.D., Delegate from Hudson County.)

The purpose of this communication is to give hope to the hopeless, inspire the hopeful, and sustain and give a feasible blueprint to that small group who are waging a valiant battle against huge odds to make Organized Medicine responsive to its membership.

The so-called "silent majority" no longer needs, if they ever did, education as to the nature and cause of contemporary problems. It is my belief that while some undoubtedly are apathetic, most are restrained by a feeling of impotence. If they could see any logical chance of success, they willingly would give any or all of the three vital ingredients for success; time, effort, and money.

Time, for the average physician, could mean no more than a few hours per month needed to attend the monthly county medical society meeting, and a few casual hours to peruse *Private Practice* and the newsletters from AAPS and PDA. Even the *AMA News* is worth a glance. To those who find time for the charade called CME, my proposal can not seem too demanding.

Effort, designed to affect change, must be channeled into writing or speaking. Many of my colleagues beg off on the modest grounds that they do not have the needed skills for either. Anyone has the potential. All that is really needed is the courage and motivation to try.

Money, though most of us have less of it or find it to have less value currently, expended in this direction can be shown to be an excellent investment. Properly directed contributions would be instrumental in maintaining or improving our future buying power.

At the recently concluded 214th Annual Meeting of the Medical Society of New Jersey, I was the leading spokesman for the cause of private practitioners and against governmental intrusion. My claim is based upon: most resolutions introduced, most issues addressed, and, unfortunately, most total time at the microphones and highest decibel rating on those occasions when persistent harrassment caused me to lose my cool.

Of the six resolutions I proposed, we prevailed on three, lost one, and suffered tactical losses on the other two.

The three that we won were:

1. Opposition to *federal subsidy* of HMO's.

2. Demanding a moratorium on further implementation of DRG's. These diagnosis related groupings are the basis of a method of hospital billing based upon the diagnosis, rather than length of stay or services rendered. I contend that this is a Kamikaze pilot study, and another case of New Jersey being "first with the worst."

3. Directing public relations priority toward exposing the high cost of compliance with governmental regulations in health care.

The direct loss was my opposition to *any type* of additional NHI.

The tactical losses were:

1. Definition of "policy." This was designed to prevent any official spokesperson from denying or reversing the will of the House of Delegates in public statements. This was withdrawn by my local County Society, through which I had submitted it, without my consent or knowledge. It did get its message across and served as a lesson to the uninitiated on how the medical political process operates.

2. My resolution opposing further federal funding of consumer-dominated HSA's seemed well on its way to passage, when another old ploy, "referral to the Board of Trustees" postponed a vote. When action is called for, procrastination must be interpreted as a defeat.

There were six other Resolutions worthy of debate.

One for retention of the current Code of Ethics, except for reference to gender, which I strongly supported, lost.

Of the five that I strongly opposed, our side won three. We defeated the following:

1. A proposal to reapportion the House and lower its number.

2. Add specialty representatives and medical students to the House as voting delegates*.

3. Support of the AMA's current version of NHI.

Their wins were:

1. A proposal for National Standards for Private Health Insurance. This was an ambiguous self-contradicting compromise between our position and theirs. It did encourage the concept of copayment.

2. Recommendation for mandatory AMA membership, which would require a 2/3 majority for the necessary constitutional amendment. We have beaten back this concept three times in the past five to six years, but only by narrow margins, despite the fact that over 90 percent of the grass-roots membership objects. I refer to this as **MIS**representation.

Since the basic structure of "organized medicine" is pyramidal, local membership at the county level is "represented" by delegates to the State Society. The State in turn sends Delegates to the AMA.

The "active" group at any level barely

***Editor's Note:** A resolution (#8) to petition the Legislature to amend MSNJ's charter to recognize the right of the Society to define the representation in its House of Delegates was adopted by the House—JMSNJ 77:Tr26 (July Transactions) 1980.

exceeds five percent. Most of those who are in that category are motivated by the opportunity it presents for gain through political and commercial avenues, or the prestige and power that come with advancement in the hierarchy. Relatively few have been willing to expend the time and effort for preservation of their right to practice good medicine.

Active involvement of all members is obviously a "pipe-dream."

A few additional "actives" at the county level sure would help. Even with the structure as it exists, merely getting some of the quiet supporters to speak up could turn the ballgame around.

I have found that trying to debate every vital issue individually, of which there are many, has the effect of progressively "turning off" the listeners. My intention for the future is to prepare my presentations on the various issues in short segments. I hope to prevail upon a handful of similarly oriented delegates to read my prepared comments or give their own version. If victory appeared assured, I need not enter the debate. If there was any question as to the outcome, I would be in a position to make the summary argument, with enough time to refute the usual half-truths and misinformation that had been glibly spouted by the opposition.

The previously outlined transactions offered a limited test of this approach, and bear strong evidence to its wisdom.

All of the significant resolutions were split between two Reference Committees, "A" on Saturday and "F" on Sunday, and debated by the House on Monday and Tuesday, respectively. This odd coincidence permitted me to follow the entire course of action.

In the Reference Committees with about fifty attendees, as compared to approximately three hundred at the House Sessions, the unsolicited support of a half dozen advocates of freedom appeared to have carried the day on every issue.

Monday came the rude awakening. In a travesty of parliamentary procedure, we went down to defeat on almost every issue. One of the men I had counted on heavily, while comparing the durability of the Code of Ethics to the Ten Commandments, was laughed at and jeered. The other supporters apparently were overwhelmed or intimidated. My bad-tempered attempt to go it alone cost me my voice, and undoubtedly the votes of those I antagonized. My anger was due in no small part to the abuse of our courtesy by one of the AMA's Trustees. With our debate time strictly rationed, he chose to filibuster for half an hour, making innumerable comments that were, to put it kindly, inaccurate. There was no allowance to refute his inaccuracy.

Monday night found me bitterly devising my future course, outside of "Organized Medicine."

Tuesday was a total turn around. Perhaps because of the shameful nature of the previous day, the atmosphere was quite different. The "good guys" spoke out loud and clear. Partially because of my wounded pride, and partially because of some good advice from my mentor, Dr. Frank Rogers, I was able to play the role that I have outlined. My limited comments were well received, and we breezed through win after win. We might have scored a clean sweep were it not for the one "referral to the Board" caper.

For all of my frustration and aggravation, in retrospect it would seem as if we took many more positive actions this year than at any time in the past. Whether the Board of Trustees and the Administrative officers will adequately implement the mandates of the House of Delegates remains to be seen.

On sober reflection, perhaps because my options are so limited, I've decided to stay in the fight for at least another year. My plan is to contact those individuals who spoke on behalf of our freedom to practice medicine as we deem best for our patients. Hopefully, we can coordinate our efforts prior to and during the next meeting. I would deeply appreciate the vote of confidence in my proposal that could be given by any delegate or member who would voluntarily contact me regarding the so sorely needed **help.**

ACR Fellows

The American College of Radiology has announced the election of two of our members to Fellowship in the College:

- Daniel S. Cukier, M.D., of Ridgewood, whose hospital affiliations include Pascack Valley Hospital, Westwood and College Hospital, CMDNJ, Newark. He also is clinical professor of radiology at New Jersey Medical School.
- William J. Esposito, M.D., of Summit, who is on the staff at the Overlook Hospital there.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Peter J. Arches, M.D., 150 Fayette Avenue, Apt. 2-H, Staten Island, NY 10305. University of East (Philippines) 1969. Board eligible. Group practice. Available.

DERMATOLOGY—Elliot C. Zweig, M.D., 14310 NE 5th Place, North Miami, FL 33161. SUNY-Downstate 1976. Also, general internal medicine. Board certified (IM). Partnership, group, associate. Available July 1981.

FAMILY PRACTICE—Leslie S. Rachlin, M.D., 1580 Four Mile Drive, Williamsport, PA 17701. Pittsburgh 1978. Group, partnership. Available July 1981.

GASTROENTEROLOGY—Michael F. Fina, M.D., 134 North Street, Apt. 7, Newtonville, MA 02160. New York Medical College 1975. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available.

Abbasi Akhtar, M.D., 333 East Ontario Street, Apt. 1512-B Chicago, IL 60611. Liaquat (Pakistan) 1966. Also, general internal medicine and pediatric gastroenterology. Board eligible. Any type practice. Available.

GENERAL PRACTICE—Gregory A. Pistone, M.D., 2018 High Street, Haddon Heights, NJ 08035. Pennsylvania State 1979. Board eligible. Student health/adolescent medicine, pharmaceutical, ER, house physician. Available.

James Walter Warren, M.D., 67 Welton Street, New Brunswick, NJ 08901. Meharry 1973. Also general internal medicine. Any type practice. Available.

Chandrakant Patel, M.D., 4855 Vazina, Apt. #14, Montreal, Quebec H3W 1BQ Canada. Gandhi (India) 1970. Group, partnership, or solo. Available.

HEMATOLOGY/ONCOLOGY—P.S. Bala, M.D., 882-6 Clifton Court Circle, NE, Atlanta, GA 30329. Calicut (India) 1965. Board eligible. Any type practice. Available.

INFECTIOUS DISEASES—Richard M. Zweig, M.D., 9952 North Kendall Drive, No. 3-M, Miami, FL 33176. SUNY-Downstate 1976. Also, general internal medicine. Board certified (IM). Partnership, group, solo, or hospital-based. Available July 1981.

INTERNAL MEDICINE—Betty J. Barcevac, M.D., 2795 Shore Parkway, Apt. 1-G, Brooklyn, NY 11223. Guadalajara (Mexico) 1976. Group, partnership, single or multi-specialty group. Available.

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Robert Lebow, M.D., 77 Grove Street, Montclair, NJ 07042. SUNY-Downstate 1977. Board eligible. Academic, partnership, multi-specialty group, industrial. Available.

Ira E. Kaplan, M.D., 523 East 14th Street, New York, NY 10009. SUNY-Downstate 1976. Special interest, cardiology. Board certified. Group, partnership. Available.

Hyung G. Kim, M.D., 1834 Beacon Street, Washington CH, OH 43160. Yonsei (Korea) 1970. Subspecialty, cardiology. Board certified. Group, partnership, or hospital-based practice. Available.

Akbar H. Obaray, M.D., 61-20 Grand Central Parkway, Apt. A-1407. Forest Hills, NY 11375. Grant (India) 1972. Subspecialty, pulmonary medicine. Board certified. Solo, group, or partnership. Available.

Bharat B. Parikh, M.D., 41-06 75th Street, Apt. 2, Elmhurst, NY 11373. Baroda (India) 1973. Subspecialty, pulmonary medicine. Board eligible. Solo or guaranteed group practice possibly leading to partnership. Available.

Fred Lewis, M.D., 7 Peter Cooper Road, Apt. 8-F, New York, NY 10010. Albany 1971. Subspecialty, endocrinology. Board certified (both). Group or hospital-based practice. Available.

Edward Lebowitz, M.D., P.O. Box 349, Lake Placid, NY 12946. SUNY-Downstate 1963. Board eligible. Group or partnership. Available.

Robert Fulop, M.D., 2678 Ocean Avenue, Apt. 5-E, Brooklyn, NY 11229. SUNY-Upstate 1978. Board eligible. Solo, partnership, group, or association. Available July 1981.

Joclekar S. Shankar, M.D., 9302 Cherry Hill Road, College Park, MD 20740. Grant (India) 1973. Board certified. Group, partnership, or hospital based. Available.

Byron S. Thomas, M.D., 513 Beachwood Court, Jacksonville, NC 28540. Pittsburgh 1975. Board certified. Group or partnership. Available November 1980.

Irwin Jaffe, M.D., 189-B Newport Road, Cranbury, NJ 08512. Zurich 1934. Board certified. Full or part-time industrial medicine or part-time with group. Available.

Peter Buch, M.D., 69-91 113th Street, Forest Hills, NY 11375. SUNY-Downstate 1976. Special interest, gastroenterology. Board certified. Group or partnership. Available July 1981.

Tej Mathur, M.D., 3071 Edwin Avenue, Apt. 3-C, Fort Lee, NJ 07024. Osmania (India) 1969. Special interest, cardiology. Group, partnership, solo. Available.

Lamberto M. Arellano, M.D., 45 Rocco Street, B-3, Belleville, NJ 07109. Santo Tomas (Philippines) 1973. Special interest, hematology/oncology. Board certified. Solo or partnership. Available July 1981.

Jacques A. Bataille, M.D., 1808 McDowell Avenue, Sharon Hill, PA 16146. Faculté de Medecine, Haiti. Solo, partnership, group. Available.

David Graber, M.D., 196 Howard Avenue, Passaic, NJ 07055. NYU 1975. Subspecialty, gastroenterology. Board certified. Group or solo. Available July 1981.

NEPHROLOGY—Jay I. Stack, M.D., 444

East 86th Street, Apt. 33-B, New York, NY 10028. University of Pennsylvania 1976. Also, general internal medicine. Board certified (IM). Group or partnership (willing to do general internal medicine). Available July 1981.

OBSTETRICS/GYNECOLOGY—T. L. Sharpe, M.D., 8309 SW 107th Avenue, Apt. D, Miami, FL 33173. Miami 1977. Board eligible. Group or partnership. Available July 1981.

PATHOLOGY—Doroteo A. Vicente, M.D., 36976 Farmbrook Drive, Mt. Clemens, MI 48043. Santo Tomas (Philippines) 1972. Both AP/CP. Board eligible. Group or partnership. Available.

Kung N. Rho, M.D., 5601 Boulevard East, Apt. 22-I, West New York, NJ 07093. Chonnam (Korea) 1959. Both AP/CP. Board eligible. Full or part-time group, institutional, or partnership. Available July 1981.

PEDIATRICS—Sunila Mehrotra, M.D., 829 Main Street, Apt. C, Belleville, NJ 07109. Delhi (India) 1974. Board eligible. Group/partnership. Available July 1981.

David R. Croughan, M.D., 12 Harbor Boulevard, East Hampton, NY 11937. Guadalajara (Mexico) 1973. Board eligible. Group, partnership. Available.

Joseph A. Weinberg, M.D., 29 Atwoodville Lane, Mansfield Center, CT 06250. Harvard 1973. Board certified. Group, partnership, associate. Available October 1980.

PSYCHIATRY—Alfredo J. do Pico, M.D., Azcuenaga 1152 Buenos Aires 1115-Argentina. Buenos Aires 1959. Board eligible. Partnership, group. Available.

PULMONARY DISEASES—Krishna Rao, M.D., 1575 Boston Avenue, Apt. C-9, Bridgeport, CT 06610. Osmania (India) 1973. Also general internal medicine. Board certified. Solo, group, hospital, partnership. Available.

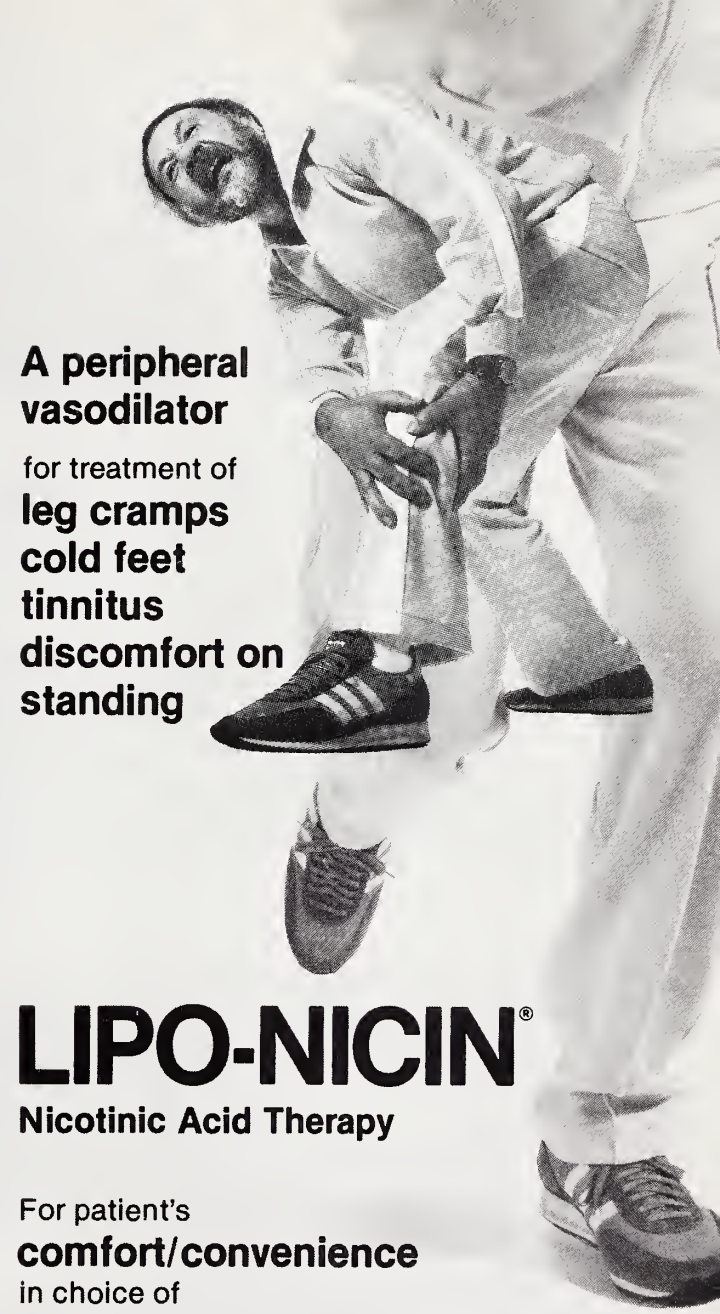
SURGERY, GENERAL—Craig J. Schaefer, M.D., 2507 North Upton Street, Arlington, VA 22207. Albany 1974. Board eligible. Group, solo, partnership. Available July 1981.

Mohammad A. Jabbar, M.D., 5103 Tiffany Place, 11315 Fondren Road, Houston, TX 77035. Guntur (India) 1966. Also, peripheral vascular surgery. Board certified. Solo, partnership, group (prefer solo). Available July 1981.

R. Nadaraja, M.D., 4B-2 Franklin Apts., Franklin Street, Morristown, NJ 07960. Ceylon 1967. Also, vascular surgery. Board certified. Group, partnership, solo, university. Available.

A. Bassal, M.D., 111 Grove St., #10, West Roxbury, MA 02132. Cairo (Egypt) 1968. Board eligible. Any type practice. Available.

UROLOGY—Vijay S. Athani, M.D., 2009 Trent Court Apartments, Lindenwold, NJ 08021. L.T. Med. College (India) 1970. Board eligible. Solo, partnership. Available.



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PERSONAL ITEM

Dr. Krosnick on ADA Board

Arthur Krosnick, M.D., a board-certified internist and the very capable editor of this *Journal,* recently was re-elected to the Board of Directors of the American Diabetes Association, a nationwide voluntary health organization serving America's ten million diabetics and their families through education, research, and community services.

A native of Trenton, Dr. Krosnick earned both his B.A. and M.D. degrees from Temple University in Philadelphia and conducted his residency in internal medicine at Presbyterian Hospital and the Graduate Hospital of the University of Pennsylvania. He is attending physician in diabetes at Mercer Medical Center in Trenton and clinical associate professor in the Department of Community Medicine at Rutgers Medical School, and a member of the advisory committee to the Office of Consumer Health Education, CMDNJ.

In addition to his activities with the American Diabetes Association, Dr. Krosnick was president of the New Jersey Affiliate in 1979 and has served on the editorial board of the Association's patient education magazine *Diabetes Forecast.* He is a member of the American Medical Association and of the American Society of Internal Medicine, and a Fellow of the American College of Physicians.

LETTER TO THE JOURNAL

Nightmares in Children and the Elderly

June 12, 1980

Dear Sir:

On the problem of nightmares in the children and the elderly, the physical surroundings of the patient are often overlooked and, I believe, are very common and easily correctable.

Being a gero-psychiatrist, I often get referrals for this condition in the elderly (at times referred to as "hallucinations"), especially those in the nursing homes and the homes for the aged. The number of blankets, setting of the air conditioner, thermostat, amount of lighting in the room and the corridor, noises in and around the room, flushing of toilets, snoring of another person in the room, if corrected, can sometimes rectify these nightmares. These elements are especially important in the elderly because if there is a drastic change in the physical surroundings from their fixed habits of many decades it is bound to upset them, sometimes in the shape of bad dreams, disturbed sleep, nightmares or "hallucinations."

This fact is of special importance in cases of the elderly who are confined, disoriented or aphasic and in young children who are not able to complain about the exact irritant, which, if not taken care of by the attending physician or the nursing staff, may go unnoticed for long periods.

(signed) J. C. Dang, M.D.

1980-1981
Committees and Councils

Standing Committees

Advisory to Women's Auxiliary

Frank R. Romano, M.D., *Chairman* (1982) ..... Dunellen
J. James Pegues, M.D., *Vice-Chairman* (1981) ..... Mount Holly
Julius Baber, M.D. (1981) ..... Bayonne
James E. Brennan, M.D. (1982) ..... Cherry Hill
Ralph J. Fioretti, M.D. (1983) ..... Rochelle Park
George T. Hare, M.D. (1983) ..... Pennsauken

Annual Meeting

Ralph J. Fioretti, M.D., *Chairman* (1981) ..... Rochelle Park
Francis X. Keeley, M.D., *Vice-Chairman* (1983) ..... Haddonfield
Joseph P. Cillo, M.D. (1982) ..... Cranford
Arthur C. Dietrick, M.D. (1981) ..... Mount Holly
Carl A. Restivo, Sr., M.D. (1982) ..... Jersey City
James H. Spillane, M.D., (1983) ..... Phillipsburg
Arthur Bernstein, M.D. (Secretary), *Ex-officio* ..... South Orange
H. Irving Dunn, M.D., *Consultant* ..... Mantoloking
Charles S. Krueger, M.D., *Consultant* ..... Mount Holly
Gabor Somjen, M.D., *Consultant* ..... Dover

Scientific Program (Sections)

Allergy
Harvey Weisslitz, M.D., *Chairman* ..... Westfield
Clement A. Maccia, M.D., *Secretary* ..... Cranford

Anesthesiology
Harvey J. Hatchfield, M.D., *Chairman* ..... Hackensack
Joseph A. Cipolla, M.D., *Secretary* ..... Scotch Plains

Cardiovascular Diseases
Daniel J. Goodman, M.D., *Chairman* ..... Hackensack
Virender Sethi, M.D., *Secretary* ..... Hackensack

Chest Diseases
Lee Reichman, M.D., *Chairman* ..... Newark
Jack Wolfsdorf, M.D., *Secretary* ..... Paterson

Clinical Pathology
Lawrence C. Sylvia, M.D., *Chairman* ..... Long Branch
John K. Ashton, M.D., *Secretary* ..... Plainfield

Dermatology
Adrian Connolly, M.D., *Chairman* ..... Orange
Frederic Haberman, M.D., *Secretary* ..... Saddle Brook

Emergency Medicine
Michael K. Sarik, M.D., *Chairman* ..... Cinnaminson
Rudolf E. Schwaeble, M.D., *Secretary* ..... Mendham

Family Practice
Salvatore J. Angelo, M.D., *Chairman* ..... Toms River
David E. Swee, M.D., *Secretary* ..... Somerset

Gastroenterology and Proctology
Michael A. Samach, M.D., *Chairman* ..... Denville
Dave B. Swerdlow, M.D., *Secretary* ..... Montclair

Medicine
John S. Sierocki, M.D., *Chairman* ..... Princeton
Mihai Z. Lupovici, M.D., *Secretary* ..... Hightstown

Neurosurgery and Neurology
Pamela S. Chavis, M.D., *Chairman* ..... Newark
Roger W. Countee, M.D., *Secretary* ..... Newark

Nuclear Medicine
Martin I. Parker, M.D., *Chairman* ..... Edison
Steven D. Richman, M.D., *Secretary* ..... Morristown

Obstetrics and Gynecology
James P. Thompson, M.D., *Chairman* ..... Upper Montclair
Daniel J. Colombi, M.D., *Secretary* ..... Cherry Hill

Oncology
Donald K. Brief, M.D., *Chairman* ..... Millburn
Rodger J. Winn, M.D., *Secretary* ..... Millburn

Ophthalmology
Mark L. Engel, M.D., *Chairman* ..... Holmdel
Leo Masciulli, M.D., *Secretary* ..... East Brunswick

Orthopedic Surgery
Edmund R. Kappy, M.D., *Chairman* ..... Red Bank
Joseph P. Pizzurro, M.D., *Secretary* ..... Ridgewood

Otolaryngology
Lindsay L. Pratt, M.D., *Chairman* ..... Camden
Alvin I. Glasgold, M.D., *Secretary* ..... New Brunswick

Pediatrics
Stephen F. Wang, M.D., *Chairman* ..... Morristown
Joseph C. Bogdan, M.D., *Secretary* ..... Neptune City

Physical Medicine and Rehabilitation
Otto Eisert, M.D., *Chairman* ..... Fair Lawn
Bernard Sandler, M.D., *Secretary* ..... Metuchen

Plastic and Reconstructive Surgery
Carl Quillen, M.D., *Chairman* ..... East Orange
Om P. Sawhney, M.D., *Secretary* ..... Plainfield

Psychiatry
Lawrence B. Erlich, M.D., *Chairman* ..... Haddonfield
George F. Wilson, M.D., *Secretary* ..... Belle Mead

Radiology
Norman Magid, M.D., *Chairman* ..... Newark
Michael Och, M.D., *Secretary* ..... Newark

Rheumatism
R. Michael Roberts, M.D., *Chairman* ..... Princeton
Edwin Woolbert, M.D., *Secretary* ..... Clifton

Surgery
Cyril S. Arvanitis, M.D., *Chairman* ..... Long Branch
Murray H. Seltzer, M.D., *Secretary* ..... Livingston

Urology
Thomas J. DeBenedictis, M.D., *Chairman* ..... Cherry Hill
Secretary to be appointed

Credentials

Arthur Bernstein, M.D., *Chairman* (Secretary), *Ex-Officio* ..... South Orange
Roger C. Laauwe, M.D., *Vice-Chairman* (1983) ..... Wayne
William A. Allgair, M.D., (1982) ..... South River
Samuel C. Ingraham, II, M.D. (1981) ..... Ocean City
Thomas E. Mattingly, Jr., M.D. (1982) ..... Mount Holly
Marcel A. Mersch, M.D. (1983) ..... Hackettstown
Lawrence B. Owen, M.D. (1981) ..... Salem

Finance and Budget

Richard E. Lang, M.D., *Chairman* (1981) ..... Passaic
William Greifinger, M.D., *Vice-Chairman* (1982) ..... Belleville
Harry M. Carnes, M.D. (1981) ..... Audubon

Palma E. Formica, M.D. (1982) ..... Old Bridge
Charles S. Krueger, M.D. (1983) ..... Mount Holly
Frank Campo, M.D. (1983) ..... Trenton
Rudolph C. Gering, M.D. (Treasurer), *Ex-Officio* ..... Pennington

Medical Defense and Insurance

Michael J. Doyle, M.D., *Chairman* (1982) ..... Neptune
Frank J. Malta, M.D., *Vice-Chairman* (1983) ..... Toms River
Paul J. Hirsch, M.D. (1981) ..... Bridgewater
Stanley Karp, M.D. (1982) ..... Cinnaminson
E. Arthur Kratzman, M.D. (1981) ..... Plainfield
Harvey P. Yeager, M.D. (1983) ..... Millburn
Arthur Bernstein, M.D. (Secretary), *Ex-Officio* ..... South Orange
Irving P. Borsher, M.D., *Consultant* ..... Newark
John J. Crosby, Jr., M.D., *Consultant* ..... Jersey City
William J. D'Elia, M.D., *Consultant* ..... Spring Lake
John D. Franzoni, M.D., *Consultant* ..... Trenton
Ernest C. Hillman, Jr., M.D., *Consultant* ..... Glen Ridge
Paul J. Kreutz, M.D., *Consultant* ..... Elizabeth
Henry Liss, M.D., *Consultant* ..... Chatham
Daniel J. O'Regan, M.D., *Consultant* ..... Lawrenceville
Jesse Schulman, M.D., *Consultant* ..... Lakewood

Medical Education

Edwin W. Messey, M.D., *Chairman* (1981) ..... Willingboro
William Pomerantz, M.D. (1982) *Vice-Chairman* ..... Randolph
Alfred A. Alessi, M.D. (1983) ..... Hackensack
Robert W. Parvin, M.D. (1982) ..... Mount Holly
Roberta G. Rubin, M.D. (1983) ..... Montclair
Sidney Woltz, M.D. (1981) ..... Union City
William C. Black, M.D., *Consultant* ..... Hackensack
S. Thomas Carter, Jr., M.D., *Consultant* ..... Collingswood
Alfonse A. Cinotti, M.D., *Consultant* ..... Jersey City
Paul J. Hirsch, M.D., *Consultant* ..... Bridgewater
William F. Minogue, M.D., *Consultant* ..... Summit
Robert S. Rigolosi, M.D., *Consultant* ..... Paramus
James A. Rogers, M.D., *Consultant* ..... Normandy Beach
John S. Thompson, M.D., *Consultant* ..... Morristown
William S. Vaun, M.D., *Consultant* ..... Long Branch

Medical Student Loan Fund

Palma E. Formica, M.D., *Chairman* (1981) ..... Old Bridge
James P. Thompson, M.D., *Vice-Chairman* (1983) ..... Upper Montclair
Antonio P. Battaglia, M.D. (1982) ..... Gibbstown
George T. Hare, M.D. (1983) ..... Pennsauken
Pasquale A. Ruggieri, M.D. (1982) ..... Vineland

Publication

Paul J. Hirsch, M.D. (1982), *Chairman* ..... Bridgewater
Julio del Castillo, M.D. (1983) ..... Trenton
John F. Marshall, M.D., (1981) ..... Trenton
Armando F. Goracci, M.D. (President-Elect), *Ex-Officio* ..... Woodbury
Arthur Bernstein, M.D. (Secretary), *Ex-Officio* ..... South Orange
Arthur Krosnick, M.D. (Editor), *Ex-Officio* ..... Trenton
Daniel B. Roth, M.D., *Consultant* ..... Teaneck

Revision of Constitution and Bylaws

Hillel M. Ben-Asher, M.D., *Chairman* (1981) ..... Morristown
Daniel J. O'Regan, M.D., *Vice-Chairman* (1982) ..... Lawrenceville
John H. Lifland, M.D. (1983) ..... Somerville
Lawrence B. Owen, M.D. (1983) ..... Salem
Carl A. Restivo, Sr., M.D. (1981) ..... Jersey City
Charles O. Tyler, M.D. (1982) ..... Camden
Arthur Bernstein, M.D. (Secretary), *Ex-Officio* ..... South Orange
William J. D'Elia, M.D., *Consultant* ..... Spring Lake
John S. Madara, M.D., *Consultant* ..... Salem
Henry J. Mineur, M.D., *Consultant* ..... Cranford
Charles I. Nadel, M.D., *Consultant* ..... Irvington

Administrative Councils

Legislation

Daniel J. O'Regan, M.D., *Chairman* (1983) ..... Lawrenceville
John D. Franzoni, M.D., *Vice-Chairman* (1982) ..... Trenton
Donald P. Burt, M.D. (1981) ..... Morristown
Anthony P. Caggiano, Jr., M.D. (1983) ..... Glen Ridge
John J. Crosby, Jr., M.D. (1982) ..... Jersey City
William J. D'Elia, M.D. (1983) ..... Spring Lake
Leon A. Fraser, M.D. (1982) ..... Trenton
S. Stuart Mally, M.D. (1982) ..... Atlantic City
Samuel B. Pole, III, M.D. (1981) ..... Bridgeton
Irving P. Ratner, M.D. (1983) ..... Willingboro
Bernard A. Rineberg, M.D. (1981) ..... New Brunswick
William Greifinger, M.D. (Chairman, Board of Trustees), *Ex-Officio* ..... Belleville

Medical Services

Victor H. Boogdanian, M.D., *Chairman* (1983) ..... New Brunswick
John S. Madara, M.D., *Vice-Chairman* (1983) ..... Salem
Joseph W. Fleisher, M.D. (1982) ..... Bayonne
Eugene H. Kain, M.D. (1982) ..... Pennsauken
Robert J. Lorello, M.D. (1981) ..... Belleville
John J. Pastore, M.D. (1981) ..... Bridgeton
Robert S. Rigolosi, M.D. (1982) ..... Paramus
William E. Ryan, M.D. (1982) ..... Pennington
Richard H. Sharrett, M.D. (1983) ..... Plainfield
Charles O. Tyler, M.D. (1983) ..... Cherry Hill
Edwin S. Wilson, M.D. (1981) ..... Moorestown
Frank A. Wolf, M.D. (1981) ..... Phillipsburg
Armando F. Goracci, M.D. (President-Elect), *Ex-Officio* ..... Woodbury
Karl T. Franzoni, M.D., *Consultant* ..... Trenton
Frank M. Galioto, M.D., *Consultant* ..... Bloomfield
Joseph A. Lepree, M.D., *Consultant* ..... Elizabeth
Nicholas E. Marchione, M.D., *Consultant* ..... Vineland
Fred M. Palace, M.D., *Consultant* ..... Mendham
James A. Rogers, M.D., *Consultant* ..... Normandy Beach

Mental Health

Harry H. Brunt, Jr., M.D., *Chairman* (1983) ..... Neptune
Farrell R. Crouse, M.D., *Vice-Chairman* (1982) ..... Woodstown
William H. Bristow, Jr., M.D. (1983) ..... Ridgewood
Joseph P. Cillo, M.D. (1981) ..... Cranford
Alvin Friedland, M.D. (1983) ..... Livingston
Raymond H. Gehl, M.D. (1982) ..... West Orange
Joseph J. Kline, M.D. (1981) ..... Trenton
Alan Kulick, M.D. (1982) ..... Vineland
Gerald H. Rozan, M.D. (1983) ..... Wayne
Nancy S. Sibert, M.D. (1981) ..... West Deptford
G.L. Triebenbacher, M.D. (1982) ..... Beach Haven
B. Ralph Wayman, M.D. (1981) ..... Morrisville, Pa.
Alfred A. Alessi, M.D. (Immediate Past-President), *Ex-Officio* ..... Hackensack
Robert S. Albahary, M.D., *Consultant* ..... Somerset
Thomas R. Houseknecht, M.D., *Consultant* ..... Moorestown
Arnold M. Kallen, M.D., *Consultant* ..... Piscataway
Martin H. Weinberg, M.D., *Consultant* ..... West Trenton

Public Health

Edward M. Coe, M.D., *Chairman* (1983) ..... Cranford
Charles J. Moloney, M.D., *Vice-Chairman* (1981) ... Moorestown
Thomas E. Desmond, M.D. (1982) ..... Edison
Mary DiMedio, M.D. (1981) ..... Woodstown
Albert Ehrlich, M.D. (1982) ..... Fort Lee
Enrico C. Funaro, M.D. (1982) ..... Morristown
Allen R. Griggs, D.O. (1983) ..... River Edge
Peter A. Gross, M.D. (1982) ..... Hackensack
Samuel C. Ingraham, II, M.D. (1981) ..... Ocean City

Patrick J. McGovern, M.D. (1981) ..... Jersey City
Watson E. Neiman, M.D. (1983) ..... Cinnaminson
Richard C. Reynolds, M.D. (1983) ..... Piscataway
Howard D. Slobodien, M.D. (First Vice-President), *Ex-Officio* ..... Perth Amboy
Ronald Altman, M.D., *Consultant* ..... Trenton
William J. Dougherty, M.D., *Consultant* ..... Trenton
Henry A. Katz, M.D., *Consultant* ..... Parsippany

Public Relations

Frank J. Malta, M.D., *Chairman* (1983) ..... Toms River
Andrew G. Hudacek, M.D., *Vice-Chairman* (1981) ..... Morristown
Milton R. Bronstein, M.D. (1982) ..... Edison
Ralph J. Fioretti, M.D. (1981) ..... Rochelle Park
Alexander D. Kovacs, M.D. (1982) ..... Scotch Plains
Robert J. Lorello, M.D. (1983) ..... Belleville
Edwin W. Messey, M.D. (1982) ..... Willingboro
Gastone A. Milano, M.D. (1981) ..... Atlantic City
James A. Rogers, M.D. (1981) ..... Normandy Beach
Victor M. Ruby, M.D. (1982) ..... Atlantic City
Jesse Schulman, M.D. (1983) ..... Lakewood
B. Ralph Wayman, Jr., M.D. (1983) ..... Morrisville, Pa.
Louis G. Bosco, M.D., *Consultant* ..... Clifton
Mark L. Engel, M.D., *Consultant* ..... Holmdel

Special Committee to Council on Medical Services

Occupational Health, Workmen's Compensation, and Rehabilitation

Maurice E. Goldman, M.D., *Chairman* ..... Linden
Mathilda R. Vaschak, M.D., *Vice-Chairman* ..... North Plainfield
George P. Bisgeier, M.D. ..... Newark
John W. Holdcraft, M.D. ..... Woodbury
Andrew G. Hudacek, M.D. ..... Morristown
M. Noel Jennings, M.D. ..... Holmdel
Daniel J. O'Regan, M.D. ..... Lawrenceville
Edwin A. Turner, Jr., M.D. ..... Upper Saddle River
Ralph A. Young, M.D. ..... Maplewood
George A. Zazanis, M.D. ..... Chatham
Joshua N. Zimskind, M.D. ..... Trenton
Elmer J. Elias, M.D., *Consultant* ..... Trenton
Eileen Measel, *Consultant* ..... Trenton
William E. Neeld, M.D., *Consultant* ..... Deepwater
John S. Tobin, M.D., *Consultant* ..... Wayne

Special Committees to Council on Public Health

Cancer Control

Benjamin F. Rush, Jr., M.D., *Chairman* ..... Newark
Bernard J. Koven, M.D., *Vice-Chairman* ..... Englewood
Sherman Garrison, M.D. ..... Bridgeton
Warren H. Knauer, M.D. ..... Hillside
Albert A. Pineda, M.D. ..... Clifton
Elissa J. Santoro, M.D. ..... Irvington
Eva B. Stahl, M.D. ..... New Brunswick
Harvey P. Yeager, M.D. ..... Millburn

Child Health

Glenn P. Lambert, M.D., *Chairman* ..... Flemington
James Q. Atkinson, M.D. ..... Medford
Anthony Brickman, M.D. ..... Trenton
William J. Farley, M.D. ..... Brielle
Douglas Ford, M.D. ..... East Orange
Robert E. Jennings, M.D. ..... South Orange
John J. LaMar, Jr., M.D. ..... Salem

Conservation of Hearing and Speech

Aris M. Sophocles, M.D., *Chairman* ..... Trenton
Howard S. Farmer, M.D. ..... Princeton
Stephen Freifeld, M.D. ..... Springfield
Patrick Houston, M.D. ..... Haddonfield
Frank L. Kardos, M.D. ..... Paterson
Rowan C. Pearce, Jr., M.D. ..... Haddonfield
Lindsay L. Pratt, M.D. ..... Camden
Robert Stern, M.D. ..... Mount Holly
Raymond B. Strauss, M.D. ..... Englewood
Albert F. Moriconi, M.D., *Consultant* ..... Trenton

Conservation of Vision

Vincent B. Pica, M.D., *Chairman* ..... Trenton
Alfonse A. Cinotti, M.D. ..... Jersey City
Ralph L. Dicker, M.D. ..... Dover
Samuel Diskan, M.D. ..... Atlantic City
Harry T. Friebel, M.D. ..... Marlton
Oram R. Kline, M.D. ..... Camden
Samuel B. Pole, III, M.D. ..... Bridgeton
Ralph A. Skowron, M.D. ..... Cherry Hill
Mark L. Engel, M.D., *Consultant* President-Elect, NJ Academy of Ophthalmology and Otolaryngology ..... Matawan

Environmental Health

Philip J. G. Quigley, M.D., *Chairman* ..... Elizabeth
Seymour Charles, M.D. ..... Irvington
Stanley R. Lane, M.D. ..... Moorestown
Richard H. Musgnug, M.D. ..... Medford Lakes
E. Spencer Paisley, M.D. ..... Haddon Heights
Frank L. Rosen, M.D. ..... Maplewood
William I. Weiss, M.D. ..... Livingston
Meyer T. Weissman, M.D. ..... Elizabeth
Morris Joselow, Ph.D., *Consultant* ..... Newark

Special Committees

Chronically Ill and Aging

David Eckstein, M.D., *Chairman* ..... Trenton
Matthew E. Boylan, M.D. ..... Avon-By-The-Sea
Werner J. Hollendonner, M.D. ..... Trenton
Lawrence J. Mazzei, M.D. ..... Hackettstown
A. Gerard Peters, M.D. ..... Paterson
Lindsay L. Pratt, M.D. ..... Camden

Degree Designation (Ad Hoc Committee)

Sherman Garrison, M.D., *Chairman* ..... Bridgeton
Frank Campo, M.D. ..... Trenton
Allen R. Griggs, D.O. ..... River Edge
John S. Madara, M.D. ..... Salem
Hormoz M. Minoui, M.D. ..... Dover
Aris M. Sophocles, M.D. ..... Trenton

Drug and Alcohol Abuse (Ad Hoc Committee)

Richard J. Corbett, M.D., *Chairman* ..... Audubon
Jorge L. Bascara, M.D. ..... Trenton
Maria L. Bergamo, M.D. ..... Newark
Thomas R. Houseknecht, M.D. ..... Moorestown
Richard M. Liss, M.D. ..... Manville
Edwin A. Turner, Jr., M.D. ..... Upper Saddle River
B. Ralph Wayman, Jr., M.D. ..... Morrisville, Pa.
Robert S. Garber, M.D., *Consultant* ..... Belle Mead
Alfred E. Palmieri, M.D., *Consultant* ..... Clifton
Riley Regan, *Consultant* ..... Trenton
Richard J. Russo, *Consultant* ..... Trenton

Emergency Medical Care

Rudolph E. Schwaeble, M.D., *Chairman* ..... Mendham
R. Winfeld Betts, M.D., *Vice-Chairman* ..... Medford
Clifford B. Blasi, M.D. ..... Sea Girt
John A. Flood, Jr., M.D. ..... Trenton
Ronald L. Franz, M.D. ..... Morrisville, Pa.
Jack R. Karel, M.D. ..... Elizabeth
Dorson S. Mills, M.D. ..... Elmer
Daniel J. O'Regan, M.D. ..... Lawrenceville

Michael D. Yablonski, M.D. ..... Hackensack
William A. Dwyer, Jr., M.D., *Consultant* ..... Paterson
Allen M. Koplin, M.D., *Consultant* ..... Trenton
Henry R. Liss, M.D., *Consultant* ..... Chatham
William Minogue, M.D., *Consultant* ..... Summit
William Reed, *Consultant* ..... Hightstown
Louis Scibetta, *Consultant* ..... Princeton

Impaired Physicians

Edward T. Carden, M.D., *Chairman* ..... Moorestown
Joyce M. Bailey, M.D. ..... Union
Lawrence F. Barnet, M.D. ..... Paterson
Philip Boyer, M.D. ..... Pennsville
David I. Canavan, M.D. ..... Paterson
Edward M. Coe, M.D. ..... Cranford
Ronald I. Forster, M.D. ..... Union
Joseph Giannasio, M.D. ..... Jersey City
A. Starr Ingram, M.D. ..... Westfield
Boris G. Ivovich, M.D. ..... Fort Lee
Andrew J.V. Klein, M.D. ..... Orange
Thomas J. Liddy, M.D. ..... Livingston
Arthur McLellan, M.D. ..... Summit
Laurence R. Mundy, M.D. ..... Denville
Ward M. Schultz, M.D. ..... New Providence
Robert Stuckey, M.D. ..... Summit
John A. Surmonte, M.D. ..... Penns Grove
Warren I. Brandwine, D.O., *Consultant* ..... Cherry Hill
Charles G. Carluccio, M.D., *Consultant* ..... West New York
Jack C. Gardner, M.D., *Consultant* ..... Piscataway
Mark Gold, M.D., *Consultant* ..... Summit
Wilber F. Kell, D.O., *Consultant* ..... Somerdale
Philip May, M.D., *Consultant* ..... South Orange
Herbert McBride, M.D., *Consultant* ..... Piscataway
Henry B. Murphree, M.D., *Consultant* ..... Piscataway
Robert Warden, D.O., *Consultant* ..... Stratford

Insurance Benefits for Psychiatric Care (Ad Hoc Committee to Review)

Howard D. Slobodien, M.D., *Chairman* ..... Perth Amboy
Arthur Bernstein, M.D. ..... South Orange
William H. Bristow, Jr., M.D. ..... Ridgewood
Anthony P. DeSpirito, M.D. ..... Neptune City
Morton Friedman, M.D. ..... Millburn
Alexander D. Kovacs, M.D. ..... Scotch Plains
Myles C. Morrison, Jr., M.D. ..... Morristown

Long Range Planning and Development

William J. D'Elia, M.D. (1983)
Chairman ..... Spring Lake
Alfred A. Alessi, M.D. (1981) ..... Hackensack
H. Oliver Brown, M.D. (1982) ..... Westfield
Philip J. LoPresti, M.D. (1981) ..... Haddon Heights
Thomas E. Mattingly, Jr., M.D. (1982) ..... Mount Holly
Bernard Robins, M.D. (1983) ..... Springfield
Benjamin Wolfson, M.D. (1981) ..... Woodbury
Sheldon Schoen, M.D., *Consultant* ..... Millburn
L. Arne Skilbred, M.D., *Consultant* ..... Glen Ridge

Maternal and Child Care

Chairman to be selected
Peter L. De Lotto, Jr., M.D. ..... Denville
Miles E. Drake, M.D. ..... Vineland
Caterina A. Gregori, M.D. ..... Livingston
Gerard F. Hansen, M.D. ..... Hackensack
John T. Harrigan, M.D. ..... New Brunswick
Michael S. Kreitzer, M.D. ..... Westfield
Edwin W. Messey, M.D. ..... Willingboro
Thomas A. Noone, M.D. ..... Haddonfield
Nicholas J. Salerno, M.D. ..... Marlton
Thomas R.C. Sisson, M.D. ..... Perth Amboy
James P. Thompson, M.D. ..... Upper Montclair
Felix H. Vann, M.D. ..... Tenafly
Margaret Gregory, M.D., *Consultant* ..... Trenton
George J. Halpin, M.D., *Consultant* ..... Trenton

Medicaid

Arganey L'A. Lucas, Jr., M.D., *Chairman* ..... Morristown
John Alexander, M.D. ..... Newark
Seymour Charles, M.D. ..... Irvington
Harvey J. Shwed, M.D., ... Newark

Medical Aspects of School Sports

Christine E. Haycock, M.D., *Chairman* ..... Newark
James E.D. Gardam, M.D. ..... Millville
Paul J. Hirsch, M.D. ..... Bridgewater
Glenn P. Lambert, M.D. ..... Flemington
Allan M. Levy, M.D. ..... Westwood
Max M. Novich, M.D. ..... Newark
Benjamin I. Smolenski, M.D. ..... Cinnaminson

Medicine and Religion

Thomas H. McGlade, M.D., *Chairman* ..... Camden
Reynold E. Burch, M.D. ..... East Orange
Edmund E. Jacobitti, M.D. ..... Maywood
John S. Madara, M.D. ..... Salem
Louis McAfoos, M.D. ..... Cherry Hill
Watson E. Neiman, M.D. ..... Cinnaminson
George A. Nitshe, M.D. ..... Monroeville
Edward W. Verner, M.D. ..... Newark
Russell L. McIntyre, Th.D., *Consultant* ..... Newark

Negotiations

Armando F. Goracci, M.D., *Chairman* ..... Woodbury
Michael J. Doyle, M.D. ..... Neptune
Harold Kallman, M.D. ..... Edison
Myles C. Morrison, Jr., M.D. ..... Morristown
Ervin Moss, M.D. ..... Verona
John J. Thompson, M.D. ..... Montclair
George A. Zazanis, M.D. ..... Chatham

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., *Chairman* ..... Vineland
Isador Gittlesohn, M.D. ..... River Edge
Paul J. Kreutz, M.D. ..... Elizabeth
Albert F. Moriconi, M.D. ..... Trenton

Task Force on IPA Project

Howard D. Slobodien, M.D., *Chairman* ..... Perth Amboy
Albert Abraham, M.D. ..... Convent Station
Christopher Babigian, M.D. ..... Paramus
Paul J. Hirsch, M.D. ..... Bridgewater
Richard E. Lang, M.D. ..... Passaic
Jon Marsicano, M.D. ..... New Brunswick
Daniel J. O'Regan, M.D. ..... Lawrenceville
Jeffrey M. Solomon, M.D. ..... Vineland
James L. Palmisano, D.D.S., *Consultant* ..... Roseland

CME CALENDAR

ANESTHESIOLOGY

Oct.

14 **Anesthesia for the Patient with Ischemic Heart Disease and a Recent MI**
7:30 p.m.—Helene Fuld Medical Center, Trenton
(Helene Fuld Medical Center and AMNJ)

Nov.

11 **Physics for the Anesthetist**
7:30 p.m.—Helene Fuld Medical Center, Trenton
(Helene Fuld Medical Center)

18 **Professional Liability and the Anesthesiologist**—Dinner Meeting
6-7 p..—Ramada Inn, Clark
(NJ Society of Anesthesiologists and AMNJ)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Oct.

1 8 15 22 29 **Recent Advances in Internal Medicine and Therapeutics**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(Middlesex General Hospital and AMNJ)

1 **Colon-Rectal Cancer**
10:30 a.m.—St. Mary's Hospital, Passaic
AMNJ

1 **Treatment of Rheumatoid Arthritis**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

1 8 15 **Medical Lecture Series**
1-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

22 and 29 **Dermatologic Manifestations of Systemic Disease (Pediatric)**
9 a.m.—Freehold Area Hospital
(AMNJ)

2 9 16 23 30 **Immunology '81**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

8 **Alcoholic Cirrhosis and Hepatic Encephalopathy**
2 p.m.—John E. Runnells Hospital, Berkeley Heights
(John E. Runnells Hospital and AMNJ)

8 **Pancreatic Diseases**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

11 **Controversies in Nutritional Support: 1980**
8:30 a.m.-1 p.m.—Sheraton-Newark International Airport Hotel
(Newark Beth Israel Medical Center, NJ Medical School, McGaw Laboratories, USV Labs and AMNJ)

14 **What's New?**
8-9:30 p.m.—Shore Memorial Hospital Somers Point
(Eli Lilly and Company, Shore Memorial Hospital and AMNJ)

14 **Atherosclerosis, Allergy and Arachidonic Acid**
1:30-5:30 p.m.—Drew University Campus, Madison
(Drew University, Ciba-Geigy Pharmaceutical Division and AMNJ)

15 **Extra Articular Manifestation of Rheumatic Disorders**
9 a.m.-1 p.m.—Rutgers Medical School, Piscataway
(NJ Chapter, Arthritis Foundation and AMNJ)

15 **Symposium on Cancer in Newark**
8:30 a.m.-4 p.m.—Robert Treat Hotel, Newark
(NJ Medical School and AMNJ)

15 **Congestive Heart Failure**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(Columbus Hospital and AMNJ)

15 **Osteoporosis**
10:30 a.m.-12 noon—Jewish Hospital, Jersey City
(Jewish Hospital and AMNJ)

15 **Thrombolytic Therapy of Venous Thrombosis**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

15 **Cancer of the Ovary**

29 **Portal-Systemic Encephalopathy**
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(Dover General, Riverside, St. Clare's Hospital and AMNJ)

15 **Congestive Heart Failure**

22 **Sexually Transmitted Disease in the 80's**

29 **The Vitamin Craze**
9:30-11 a.m.—Bergen Pines County Hospital
(Bergen Pines County Hospital and AMNJ)

16 **2nd Echocardiography**
2-3 p.m.—Deborah Heart and Lung Center, Browns Mills
(Deborah Heart and Lung Center)

20 **Hepatic Coma**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

21 **Medical Problems Associated with Jogging**
Noon—St. Mary's Hospital, Orange
(St. Mary's Hospital and AMNJ)

21 **Coronary Artery Disease**
2 p.m.—Ancora Psychiatric Hospital
(Ancora Psychiatric Hospital and AMNJ)

23 **Diagnostic/Therapeutic Decision Making in Common Gastrointestinal Problems**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

25 **Diagnosis and Treatment of Skin Tumors**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

29 **Latest Treatment for the New and Old Sexually Transmitted Diseases**
9 a.m.-4 p.m.—St. Barnabas Medical Center, Livingston
(Essex County Medical Society, NJ Department of Health, St. Barnabas Medical Center and AMNJ)

29 **Immunology (Clinical)**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

31 **Lipids and Cardiovascular Disease**
8:30-9:30 a.m.—Chilton Memorial Hospital, Pompton Plains
(Chilton Memorial Hospital and AMNJ)

Nov.

5 **Otitis Media**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

5 **Blood and Blood Component Therapy**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(Columbus Hospital and AMNJ)

5 **Nutritional Aspects of Cancer Treatment**

26 **Beta Blockade and Its Many Uses**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

5 **Burns**

12 19 26 **Medical Lecture Series**
1-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

5 12 19 26 **Internal Medicine and Therapeutics**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(Middlesex General Hospital and AMNJ)

6 13 20 **Immunology '81**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

DELAWARE VALLEY SOCIETY FOR G. I. ENDOSCOPY

Presents

"THERAPEUTIC ENDOSCOPY"

October 22, 1980
Philadelphia County Medical Society
2100 Spring Garden Street, Philadelphia, Pa.
1:00-5:30 p.m.

PANELS

I CONTROL OF G. I. BLEEDING 1:00-3:00 p.m.

1:00 "Overview"—Dave Falkenstein, M.D.
1:15 "Control of Esophageal Variceal Bleeding"—Worth Boyce, M.D.
1:30 "Electrocoagulation in Ulcers and 'Itis' "—John Papp, M.D.
1:45 "Colonoscopic Bleeding Control"—Bergen Overholt, M.D.
2:00 Panel
Moderator: William Mahood, M.D.
Worth Boyce, M.D. — Bergen Overholt, M.D.
Dave Falkenstein, M.D. — John Papp, M.D.
3:00 Coffee, Coke and Danish

II OPERATIVE ENDOSCOPY 3:30-5:30 p.m.

3:30 "Insertion of Esophageal Prosthesis—Technique and Results"—Worth Boyce, M.D.
3:45 "UGI Polypectomy and Bezoar Removal"—John Papp, M.D.
4:00 "Operative Endoscopy in and around the Papilla of Vater"—Dave Falkenstein, M.D.
4:15 "Complicated Colonic Polypectomy"—Bergen Overholt, M.D.
4:30 Panel
Moderator: Norman N. Cohen, M.D.
Worth Boyce, M.D. — Bergen Overholt, M.D.
Dave Falkenstein, M.D. — John Papp, M.D.

AMA CME Category I ..... 4 hours credit

Registration:	**$50.00**	**Physicians in Training**	**$15.00**
		G.I. Assistants	**$15.00**
Members of the Delaware Valley Society for G.I. Endoscopy			**$40.00**

Make check Payable to: Delaware Valley Society for G. I. Endoscopy and mail to:
Norman N. Cohen, M.D., Program Chairman
Mercy Catholic Medical Center
Darby, Pennsylvania 19023

8 **Bleeding Diseases**
8:30 a.m.-5 p.m.—Rutgers Medical School, Piscataway
(AMNJ)

11 **Peptic Ulcer**
8-9:30 p.m.—Shore Memorial Hospital, Somers Point
(SKF Laboratories and AMNJ)

12 **The New Antibiotics**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(Columbus Hospital and AMNJ)

12 **Basic Mechanisms in Asthma**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

12 **Hypercalcemia in Geriatric Patients**
2 p.m.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)

12 **Decreasing Cardiac Events Post-Infarction**
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(Dover General, Riverside and St. Clare's Hospitals and AMNJ)

13 **Small Parts Ultrasonography**
7:30-9:30 p.m.
(NJ Institute of Ultrasound in Medicine and AMNJ)

14 **ACP New Jersey Regional Meeting**
All Day—Meadowlands Hilton, Secaucus
(NJ Chapter, American College of Physicians Bergen Pines County Hospital and AMNJ)

17 **Skin Signs of Systemic Disease, Part II**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

18 **Thyroid Function Tests**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

18 **Diabetes**
2 p.m.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

18 **Endocrinology and Metabolism**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

20 **Appropriate Uses of Tranquilizers**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

21 **Pulmonary Diseases**
12 noon—Freehold Area Hospital
(AMNJ)

25 **Topic to be Announced**
7:30-9:30 p.m.—Coachman Inn, Cranford
(New Jersey Blood Club and AMNJ)

25 **Current Radiation Therapy**
8 a.m.—Princeton Medical Center
(AMNJ)

NEUROLOGY/PSYCHIATRY

Oct.

1 **Eating and Weight Disorders**
9:30 a.m.-4:15 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

3, 10 **Psychodynamic Factors in the Treatment Process**
2:45-3:45 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

3, 10, 17, 24 **Emotionally Disturbed Child**
1:30-2:30 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

3, 10, 17, 24, 31 **Neuranatomy/Neuropathology and Clinical Neurology**
4-5 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

4 **Integrating Individual and Family Therapy**
9 a.m.-2 p.m.—Holiday Inn, Livingston
(New Jersey Center for Family Studies and AMNJ)

4 **Prevention of Mental Illness in Children**
8:45 a.m.-4:30 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital, NJ Council of Adolescent Psychiatry and AMNJ)

6 **Man with Success Inhibition**
8-10 p.m.—9 Marquette Rd., Upper Montclair
(Essex Psychiatric Doctor's Seminars and AMNJ)

7 **Psychotherapy of Schizophrenia**
11 a.m.—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

8 **Stress in the Family of the Mentally Ill Patient**

15 **Issues in Weight Control: Bulemia Nervosa**

22 **Theories of Group Psychotherapy**

29 **Sleep Disorders**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

8 **The Widening Scope of Psychoanalysis**
8:30-10:30 p.m.—Guido's Restaurant, Hackensack
(NJ Psychiatric Society and AMNJ)

9 **Lithium-Induced Diabetes Insipidus and Diuretics as Treatment**

16 **Facilitating Group Process Through Art Therapy**

22 **The GI Tract and Psychiatry**

30 **Lithium Update and Alternatives to Lithium**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

11 **Problems of Adopted Children**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

15 **Newer Treatments in Psychiatry**
1-4 p.m.—Camden County Health Services Center, LaGaleire Psychiatric Hospital, Blackwood
(Camden County Health Services Center and AMNJ)

15 **Professional Stress "Burn Out"**
1:30 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

17, 24 **Emergency Psychiatry**
2:45-3:45 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

18 **Psychological Components of Learning Disabilities**
9 a.m.-5 p.m.—Rutgers Medical School, Piscataway
(Perceptions, NJ Academy of Pediatrics and AMNJ)

21 **Drug Addiction**
11 a.m.—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

22 **Updating Psychophysiologic Disorders**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

22 **Gastrointestinal Illness and Emotions**
4-6 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

31 **Forensic Psychiatry**
2:45-3:45 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

31 **Geriatric Psychiatry**
1:30-2:30 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

Nov.

3 **Anorexia Nervosa in Adult Women**
8-10 p.m.—4 Garden Place, Nutley
(Essex Psychiatric Doctor's Seminars and AMNJ)

5 **Forensic Medicine**

19 **Community Psychiatry**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

5 **Diagnosis of Borderline Conditions**

12 **Munchhausen's Syndrome**

19 **Assertiveness Training**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

6 **Case Reviews**

13 **Psychopharmacology and Compliance Issues**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundatitn and AMNJ)

7, 14, 21 **Geriatric Psychiatry**
1:30-2:30 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

7, 14, 21 **Neuronatomy/Neuropathology and Clinical Neurology**
4-5 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

7, 14, 21 **Forensic Psychiatry**
2:45-3:45 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

10 **Drinking Patterns of Adolescents**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

19 **Sleep-Wake Disorders**
9:30-11 a.m.—Bergen Pines County Hospital
(Bergen Pines County Hospital and AMNJ)

19 **Update on Psychotropic Medications**
1:30 p.m.—Trenton Psychiatric Hospital
(AMNJ)

The Basic Science Section of the
COLLEGE OF PHYSICIANS OF PHILADELPHIA

offers a postgraduate seminar

THE KIDNEY: BASIC SCIENCE AND CLINICAL PRACTICE

FRIDAY, NOVEMBER 21, 1980
to be presented by:

Michael W. Weiner, M.D.
Assistant Professor of Medicine
Stanford University School of Medicine
Palo Alto, California

Robert Narins, M.D.
Professor of Medicine
Temple University School of Medicine
Philadelphia, Pennsylvania

APPROVED FOR SIX HOURS AMA CATEGORY I CREDIT

For further information contact Mrs. Dagny Henderson, College of Physicians of Philadelphia, 19 South 22nd St., Philadelphia, PA 19103, (215) 561-6050, Ext. 31 or 48.

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October 31, November 1, and 2, 1980
BARBIZON PLAZA HOTEL, NEW YORK CITY

Accreditation
As an organization accredited for continuing medical education, the New York University Post-Graduate Medical School certifies that this continuing medical education offering meets the criteria for 30 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Course Description
Chronic pain, including chronic facial pain, is among the most difficult of challenges to confront the practicing clinician. In the management of chronic pain, acupuncture is a most valuable tool when properly applied. This course, presented by authorities who have long been outstanding in the field, is designed to provide an update on the role of acupuncture in pain control, as well as in the clinical applications. Essential information and techniques will be presented for advanced as well as beginner students, and the course will include patient presentations and clinical instruction in the use of acupuncture. The course is approved by the New York State Boards for Medicine and Dentistry for 30 credit hours towards the State Acupuncture certification requirement. For further information and application write:

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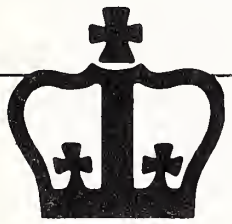

THE COLLEGE OF PHYSICIANS & SURGEONS, COLUMBIA UNIVERSITY
Postgraduate medicine courses for *September* through *November:*

Renal Biopsy In Medical Diseases of the Kidney, Sept. 29 to Oct. 3, 1980. Fee: $400 (resident's fee: $200) includes syllabus, Kodachrome slides, electronmicrographs of "classic" renal lesions, luncheons. (35 credit hours). Conrad Pirani, M.D.

Advances in Surgical Pathology, Oct. 6-8, 1980. Fee: $300 (or $125 per day); resident's fee: $150 (or $60 per day) includes syllabus and luncheons. (24 credit hours). Cecilia Fenoglio M.D. and Luciano Ozzello, M.D.

Symposium On The Optic Nerve, Oct. 9 and 10, 1980. 11th Annual Course of Edward S. Harkness Eye Institute. Fee: $200 (resident's fee: $100) includes luncheons. (14 credit hours). Myles M. Behrens, M.D.

20th Annual Review Course In Obstetrics and Gynecology, Oct. 20-24, 1980, Fee: $375 (resident's fee: $200), includes luncheons and syllabus. 37 credit hours, Category 1, A.M.A.'s P.R.A.; 35 Cognates, A.C.O.G.; 33 1/2 credits, A.A.F.P. Raymond Vande Wiele, M.D.

Basic Medical Hypnosis, Oct. 27-30, 1980. *Fee: $400 (resident's fee: $300). (32 credit hours). Herbert Spiegel, M.D., Barbara DeBetz, M.D., David Spiegel, M.D.

Hypnosis and Psychiatry, March 23-26, 1981. *Fee: $400 (resident's fee: $300). (32 credit hours). Herbert Spiegel, M.D., Barbara DeBetz, M.D., David Spiegel, M.D. *If **Hypnosis and Psychiatry** and **Basic Medical Hypnosis** are registered for at the same time, the combined fee is $700 (resident's fee: $550).

Postgraduate Review Course of Procedures Used In The Practice of Allergy, Nov. 5-7, 1980, at the New York Academy of Medicine. Cosponsored by the American Academy of Allergy, R.A. Cooke Institute of Allergy of St. Luke's-Roosevelt Hospital Center. Fee: $250 (resident's fee: $125) includes luncheons. (22 credit hours). Michael Grieco, M.D., William Kniker, M.D.

Postgraduate Review Course in Neuroanatomy, Neurophysiology, and Neuropharmacology, Nov. 13, 1980—April 4, 1981 (20 Sats., 9:30-Noon). Fee: $420 (resident's fee: $210). (42 credit hours). Edgar M. Housepian, M.D.

Names of Course Directors follow each listing. All courses are approved for Category 1 credit of the A.M.A.'s Physician's Recognition Award. Contact: DR. ELIZABETH C. GERST, Director, Continuing Education Center, College of Physicians & Surgeons, 630 West 168th Street, New York, N.Y. 10032; telephone: (212) 694-3682.

OBSTETRICS/GYNECOLOGY

Oct.

22 Sonographic Human Development
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(Columbus Hospital and AMNJ)

23-26 Sixth Annual Ignatz Semmelweis Obstetrical Seminar
Cherry Hill Inn, Cherry Hill
(CMDNJ and AMNJ)

PATHOLOGY

Oct.

21 Laboratory Interpretation
8 a.m.—Medical Center at Princeton
(AMNJ)

Nov.

12 Clinical Pathology Conference
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

19 Forensic Pathology
9 a.m.-5 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

PEDIATRICS

Oct.

2 Dermatologic Manifestations of Systemic Disease (Pediatric)
9 a.m.—Freehold Area Hospital
(AMNJ)

8 Pediatric Ophthalmology
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(Columbus Hospital and AMNJ)

Nov.

6 Pediatric Malabsorption Syndrome
9 a.m.—Freehold Area Hospital
(AMNJ)

15 Pediatric Plastic Surgery
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

RADIOLOGY

Oct.

9 Topic to be Announced
7:30-9:30 p.m.—VA Medical Center, Lyons
(NJ Institute of Ultrasound in Medicine and AMNJ)

9 Survey of Ultrasonic Instrumentation
7:30-9:30 p.m.—Overlook Hospital, Summit
(NJ Institute of Ultrasound in Medicine and AMNJ)

9 Nuclear Methods in Cardiology
8-9 p.m.—Deborah Heart and Lung Center, Browns Mills
(Burlington County Medical Society and AMNJ)

16 Bone Diseases
8 p.m.—Hospital Center at Orange
(Radiological Society of NJ and AMNJ)

23 Visiting Professorship Program
1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston
(St. Barnabas Medical Center)

Nov.

13 Visiting Professorship Program
1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston
(St. Barnabas Medical Center)

19 Dinner Meeting
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

20 Topic to be Announced
8 p.m.—Hospital Center at Orange
(Radiological Society of NJ and AMNJ)

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastic, and Vascular Surgery.)

Oct.

1 Open Heart Surgery in a Community Hospital—(St. Barnabas)
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(Columbus Hospital and AMNJ)

1 Balloon Angioplasty
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

8 Pediatric Ophthalmology
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(Columbus Hospital and AMNJ)

22 NJ Academy of Ophthalmology and Otolaryngology Annual Meeting
9 a.m.-5 p.m.—Town and Campus, West Orange
(NJ Academy of Ophthalmology and Otolaryngology and AMNJ)

28 Management of Pressure Sores
8-10 p.m.—Englewood Hospital, Englewood
(Englewood Hospital and AMNJ)

Nov.

5 Microsurgery in Treatment of Infertility
8-10 p.m.—Clairidge House #2, Apt. 12, Verona
(NJ Medical Women's Association Journal Club and AMNJ)

19 Cancer of the Bladder

26 Advances in Orthopedics
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(Columbus Hospital and AMNJ)

25 Proficiency in Microsurgery
8-10 p.m.—Englewood Club, Palisade Ave., Englewood
(Englewood Surgical Society and AMNJ)

26 Vascular Disorders of the Intestines
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(Dover General, Riverside and St. Clare's Hospitals and AMNJ)

MISCELLANEOUS

Oct.

1 Legal Aspects of Medical Care
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(Dover General, Riverside and St. Clare's Hospitals and AMNJ)

6 Selective Surgical Treatment of Breast Cancer
7:45-9 a.m.—Newark Beth Israel Medical Center
(Newark Beth Israel Medical Center and AMNJ)

8 Jogging: The Physician's Role
9:30-11 a.m.—Bergen Pines County Hospital
(Bergen Pines County Hospital and AMNJ)

17 Malpractice
12 noon—Freehold Area Hospital
(Freehold Area Hospital and AMNJ)

21 Medical Problems Associated with Jogging
12 noon—St. Mary's Hospital, Orange
(AMNJ)

28 Malpractice
8 a.m.—Medical Center at Princeton
(AMNJ)

6th Annual Ignatz Semmelweis Obstetrical Seminar

October 23-26, 1980

Cherry Hill Inn, Cherry Hill, New Jersey

The major emphasis of the program will be to provide the learner with the latest information on diagnostic aids and possibilities for intervention in preventing birth defects.

This program has been approved for credit by AMA, ACOG, AOA, AAFP.

For further information, please contact Rose Adler, CMDNJ-Office of Continuing Education, 100 Bergen Street, Newark, New Jersey 07103 (201) 456-4267.

Registration fee:

$215 for practicing physicians
$130 for resident in training and nurses
10% reduction in tuition fee if payment returned with this ad.

OBITUARIES

Dr. Charles M. Aronsohn

On July 6, Charles M. Aronsohn, M.D., a member of our Passaic County component, died at his home. A native of New Jersey, born in 1917, Dr. Aronsohn was graduated from Long Island University College of Medicine in 1942 and pursued a residency in internal medicine at Paterson General Hospital. He was on the active staff at Paterson General and Barnert Memorial Hospitals. For three years (1973-1976) Dr. Aronsohn lived and practiced in Honolulu and was on the staff at the Kuakini and Queens Medical Centers. During this period he maintained an affiliate membership with the Medical Society of New Jersey. Dr. Aronsohn was a member of the Academy of Medicine of New Jersey.

Dr. Raul R. Betancourt

Notice just has been received of the death on January 17 of Raul R. Betancourt, M.D., former chief of urology at Cooper Medical Center, Camden, Underwood Memorial Hospital in Woodbury, and Zurbrugg Memorial Hospital, Riverside. A native of Havana, Cuba, Dr. Betancourt was graduated from the University of Havana School of Medicine in 1928 and pursued a residency in urology at the Mayo Clinic in Rochester, Minnesota, becoming board certified in that specialty. He took further graduate training at the Graduate Hospital of the University of Pennsylvania. He was a Fellow of the American College of Surgeons, and a member of the New Jersey Society of Surgeons and of the American Urological Association. Dr. Betancourt retired from active practice in 1972 and recently had been living in Philadelphia. During World War II he served in the department of medicine of the AUS. Dr. Betancourt was 77 years old at the time of his death.

Dr. Louis Butan

On May 26, Louis Butan, M.D., formerly of East Orange and a member of our Essex County component, died in Boca Raton, Florida, where he was living in retirement. Born in Newark in 1913, Dr. Butan was graduated from Cincinnati University Medical School, class of 1938 and had practiced general medicine in the Oranges until retirement in 1978. He had been on the staff at St. Mary's Hospital in Orange. During World War II, Dr. Butan served with the medical department of the AUS.

Dr. Joseph I. Echikson

We just have learned of the death of one of Essex County's senior members, Joseph I. Echikson, M.D., on May 4 at Saint Barnabas Medical Center, Livingston, following a cerebrovascular accident. A graduate of Columbia University College of Physicians and Surgeons, class of 1921, Dr. Echikson had practiced internal medicine in Maplewood for many years. He was board certified in that specialty and was a Fellow of the American College of Cardiologists, and the American Society of Clinical Pathologists. He was past president of his county medical society and of the Academy of Medicine of New Jersey. His hospital affiliations included Martland and Presbyterian in Newark, Irvington General, Saint Barnabas Medical Center in Livingston, Clara Maass Memorial in Belleville, and consultant at the Essex County Sanatorium for Tubercular Diseases and the Kessler Institute. Dr. Echikson was active in the American Cancer Society for many years and had been chairman of the executive committee of the New Jersey division. He received the 1952 American Cancer Society Award in recognition of outstanding work in that field. Dr. Echikson was lauded in 1960 by the South Mountain Lodge of B'nai B'rith by being named recipient of its Americanism Award. In 1971 he received MSNJ's Golden Merit Award indicating fifty years of medical practice. Dr. Echikson, who was 82 years old at the time of his death, had retired in the early 1970s.

Dr. H. Hale Hollingsworth

H. Hale Hollingsworth, M.D., formerly of Clifton, died on June 25 in Fort Myers, Florida where he had been living in retirement since 1960. Born in Lewisville, Indiana in 1894, Dr. Hale was graduated from the University of Pennsylvania School of Medicine in 1922 and practiced in his home community until coming to Passaic County in 1926 as chief of surgery at the New Jersey Manufacturers Hospital in Clifton.

Dr. William Jacobs

An affiliate member of MSNJ, formerly from Essex County, William Jacobs, M.D., died on July 2 in El Paso, Texas where he had been living since 1975. A native of New York City, born in 1909, Dr. Jacobs was graduated from George Washington University School of Medicine in 1935 and practiced general medicine and surgery in Irvington and Orange for many years. He was in limited practice in El Paso as medical director of two nursing homes. While in New Jersey he had been on the attending staff at St. Barnabas Medical Center, Livingston and Irvington General Hospital. During World War II Dr. Jacobs served with the medical department of the United States Army.

Dr. Leo Kohn

A member of our Essex County component, Leo Kohn, M.D., of South Orange, died on June 9. A native of Massachusetts, Dr. Kohn was graduated from the Columbia University College of Physicians and Surgeons in the class of 1934

and had practiced general medicine in South Orange until retirement in 1976. He had been affiliated with East Orange General and the Hospital Center at Orange. During World War II Dr. Kohn served with the medical department of the AUS. He was in his seventieth year at the time of his death.

Dr. J. Harold MacArt

J. Harold MacArt, M.D., a member of our Essex County component, died on June 3 in Nokomis, Florida where he had been living in retirement since 1975. A native of Pennsylvania, born in 1910, Dr. MacArt was graduated from Hahnemann Medical College in 1935 and pursued a career in surgery, attaining Fellowship in the American College of Surgeons. He had been on the surgical staff at East Orange General and the Hospital Center at Orange, Presbyterian Hospital in Newark, and St. Barnabas Medical Center in Livingston. Dr. MacArt was a member of the Academy of Medicine of New Jersey and had served in the United States Navy during World War II.

Dr. Russell S. Magee

At the grand age of 82, Russell S. Magee, M.D., of Audubon, a member of our Camden County component, died on June 26. A native of Philadelphia, Dr. Magee was graduated from Hahnemann Medical College in 1923 and practiced general surgery in Camden County for many years. He was a Fellow of the American College of Surgeons and had been chief of surgery at St. Luke's Hospital and Children's Medical Center in Philadelphia. Dr. Magee also was a member of the International College of Surgeons. He was a recipient of MSNJ's Golden Merit Award in 1973 in recognition of his 50 years of medical practice.

Dr. Isaac N. Patterson

Isaac N. Patterson, M.D., a member of our Gloucester County component, died on June 13. A native of south Jersey, born in 1908, Dr. Patterson was graduated from the University of Virginia School of Medicine in 1934 and practiced family medicine (with special interest in gastroenterology) in Gloucester County for many years. He had been affiliated with Underwood Hospital in Woodbury and Cooper Medical Center in Camden. Dr. Patterson was active in organized medicine and had served three terms as an AMA delegate from New Jersey. During World War II he was an officer with the medical department of the Army of the United States.

Dr. Ralph Salsberg

A well-known dermatologist, now retired, Ralph H. Salsberg, M.D., died on June 21 in East Orange General Hospital. Born in Canada at the turn of the century, Dr. Salsberg was graduated from the medical school of Queens University in Kingston, Ontario (Canada) in 1918. He came to New Jersey 52 years ago, after practicing briefly in Kingston. He had been affiliated with Beth Israel Medical Center and Martland Hospital in Newark where he had offices for many years, and with East Orange General Hospital. Dr. Salsberg was a Fellow of the American Academy of Dermatologists and a member of the Society for Investigative Dermatology and of the New Jersey Dermatological Society.

Dr. Samuel G. Scott

One of Hudson County's senior members, Samuel G. Scott, M.D., of Jersey City, died on July 7 in Christ Hospital in Jersey City. Born in 1884 in Jamaica, BWI, and graduated from Jefferson Medical College in 1924, Dr. Scott practiced general medicine in Hudson County for many years. He first was graduated from Brooklyn College of Pharmacy and was a practicing pharmacist until he entered medical college in 1920. He had been on the staff at Margaret Hague and Fairmount Hospitals in Jersey City and Jersey City Medical Center. Dr. Scott retired from practice in 1979. He was a recipient of MSNJ's Golden Merit Award in 1974 which marked 50 years in the practice of medicine.

Dr. Frank Xhilone

On June 14, Frank Xhilone, M.D., a member of our Salem County component, died at his home. Born in 1924 and graduated from the medical school of the University of Milan (Italy) in 1955, Dr. Xhilone pursued a career in family practice in Woodstown and had been affiliated with Salem Memorial Hospital. He was a member of the American Academy of Family Practice.

Dr. John A. Zingali

John A. Zingali, M.D., a member of our Essex County component, died on June 13. A native of New York City, born in 1910, Dr. Zingali was graduated from Long Island College of Medicine in 1936 and practiced general medicine for several years before pursuing his interest in industrial medicine. More recently he had been physician for New Jersey Manufacturers Clinic in Clifton and was on the staff at St. Vincent's Hospital in Montclair. During World War II Dr. Zingali served with the United States Public Health Service.

BOOK REVIEWS

Current Pediatric Diagnosis and Treatment, 6th ed.

D. Kempe, K. Silver, D. O'Brien, Los Altos, CA, Lange, 1980. Pp. 1122. Illus. ($20)

A current therapy should have certain features: (1) Specific, precise and easy-to-follow advice, (2) A consensus of authority or an indication of extremes where there is no consensus, (3) Problem oriented approach, (4) Recent references to the periodic literature, (5) Classifications of therapies: chemical, educational, and other, (6) An appropriate balance between the general and the specific.

I compared the Kempe volume with the Gellis *Current Therapy*. The Kempe volume is both a therapy and a diagnostic outline, therefore, it endeavors to cover more ground. In some ways, this is advantageous for the reader.

There are better outlines of development, ambulatory care and adolescent medicine. The book suffers from a lack of specific instructions on therapy. In many instances, descriptions indicate the use of one modality or another, but specifics are not given. The authors leave it to the reader to trace through the index to find drug dosages. The Gellis volume compares much more favorably in this regard.

Neither book deals well with jaundice as a problem. I could not find a mention of breast milk jaundice. The Gellis volume comes out ahead on newborn problems and lactation and has a better formulary for dermatologic care.

If I could only have one, I would prefer the Gellis volume, but there are many areas where the Kempe book is more complete, and more useful. If you can afford it, have both.

Avrum L. Katcher, M.D.

Handbook of Obstetrics and Gynecology, 7th ed.

Ralph C. Benson, M.D. Los Altos, CA, Lange, 1980. pp. 808. Illus. ($10)

This book brought back memories of my internship. It was the most popular handbook of obstetrics and gynecology and was used by medical students, interns and residents.

The first edition was published in 1964 and was an instant success. In this seventh edition the author has made revisions and additions stressing the clinical and practical aspects of the specialty without ignoring modern basic science information when considered necessary. New topics have been added, including diseases of the breast, puberty, amenorrhea, and evaluation of fetal status, and additional information is presented on medical complications of pregnancy, abortion, venereal disease, contraception and oncology. Some chapters have been completely rewritten.

It is the reviewer's opinion that this handbook is one of the best, if not the best digest of the specialty currently available. It is popular in the United States and abroad. There are Spanish, Portugese, Italian, and Polish language editions.

I recommend this handbook without hesitation to anyone who requires modern, concise, and readily available information concerning common obstetrical and gynecological problems.

Marco A. Pelosi, M.D.

Emergency Handbook. A First Aid Manual for Home and Travel.

P. Arnold and E.L. Pendagast, Jr. New York, Doubleday, 1980. Pp. 250. Illus. ($11.95).

This is an excellent manual and well written in simple language that easily can be comprehended. Emergency situations are categorized in alphabetical order. Illustrations are easily understood. This book would be extremely valuable in every home and could also be a quick review for every family practitioner. It is divided into six sections (1) Sudden Emergencies, (2) Be Prepared, (3) Care at Home, (4) First Aid Away from Home, (5) An Ounce of Prevention, (6) Fire Safety. The book covers every emergency from abrasions to ulcers of the stomach. It refers to the six most important responses for major medical emergencies—(1) make sure the victim is breathing, (2) stop any heavy bleeding, (3) prevent further injury, (4) anticipate shock, (5) do not do more than you know, (6) have someone seek medical help.

Jack R. Karel, M.D.

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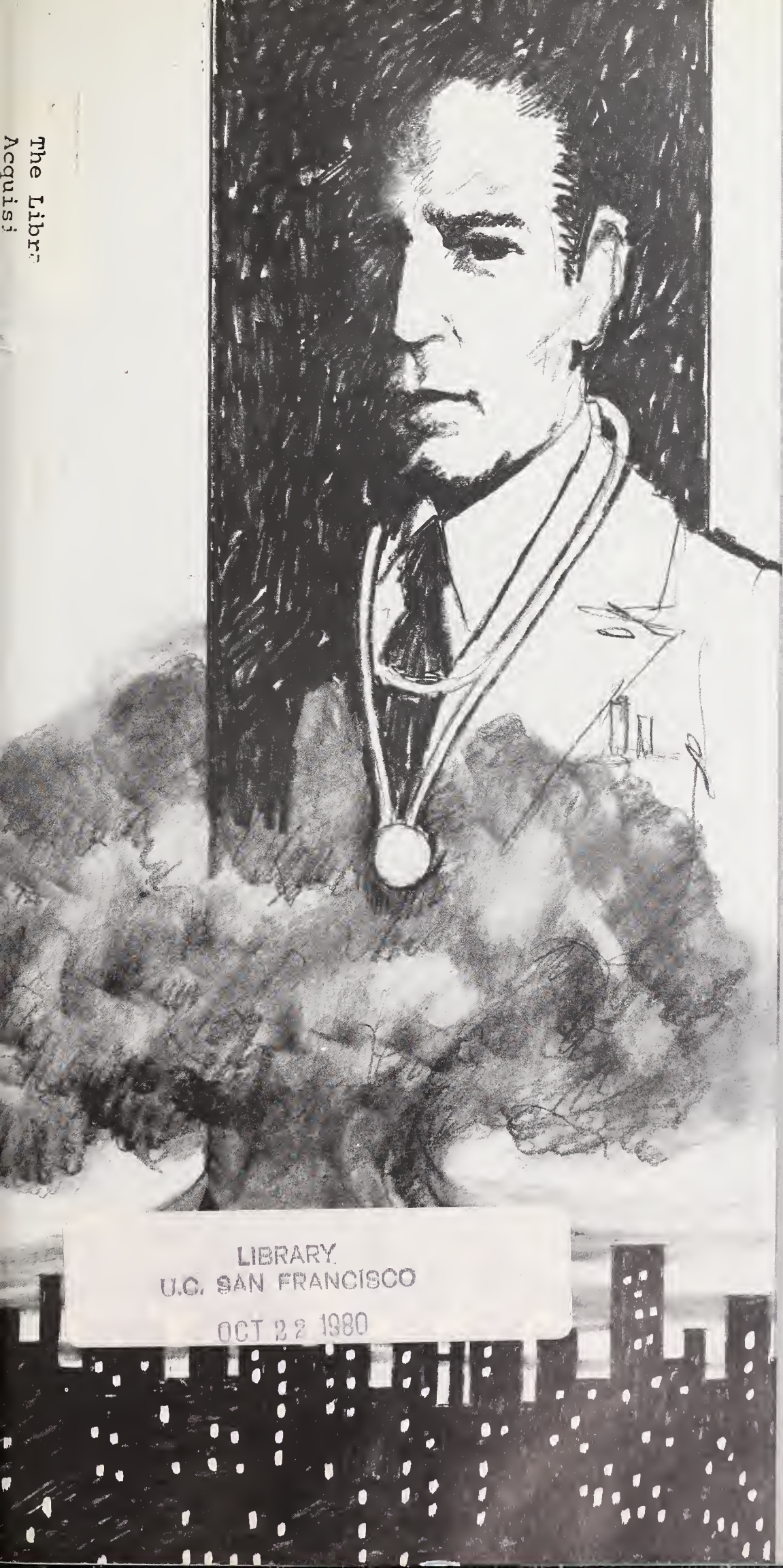

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The cover is a pen-and-ink drawing by Elizabeth Ruggles. Miss Ruggles is a well-known teacher and painter in the area and formerly was staff artist for the New Jersey State Department of Health.

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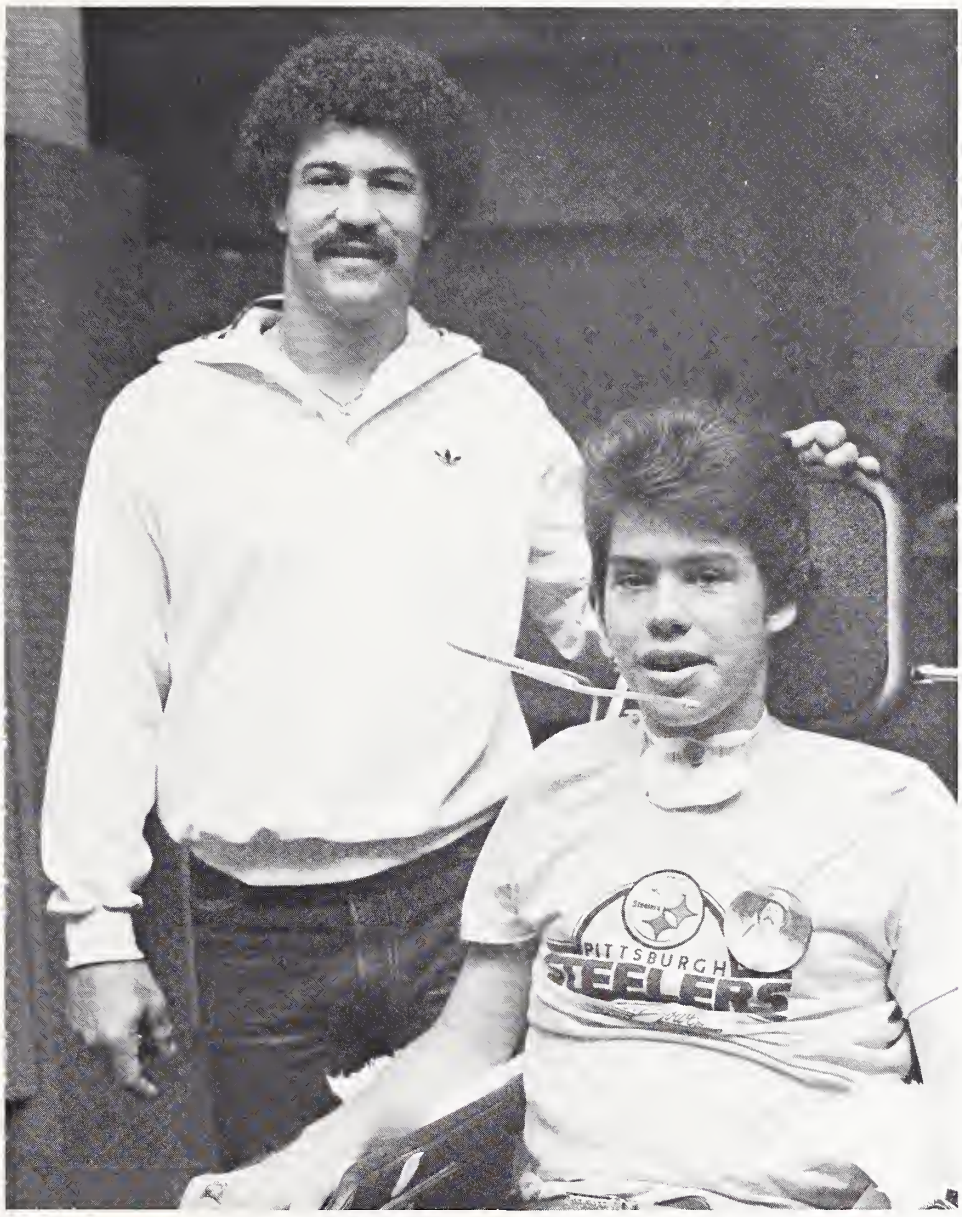

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Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Medical Malpractice Law Update
Amniocentesis and Informed Consent for Patients of Advanced Maternal Age

STANDARDS OF CARE FOR DEFENSE COUNSEL

The important area of professional conduct on the part of a physician's defense counsel was discussed in the case of *Bevevino v. Saydjari,* 76 F.R.D. 88, aff'd. 574 F. 2d 676 (1978) (PLB Vol. 1, No. 2). The Bevevino case stands as an example of gross mishandling of a physician's professional liability case by his insurance carrier and defense attorney.

The facts reveal that the plaintiff, Victor Bevevino, a former professional soccer player, sued the hospital and an emergency physician alleging that negligent medical care caused the loss of his right eye. The jury returned a verdict of $550,000 in favor of the plaintiff. The physician's malpractice insurance carrier moved to set aside the jury verdict.

Despite the appellate court's opinion that the jury's finding of liability was altogether unwarranted, it refused to grant the defendant's motion to set aside the verdict. The appellate court concluded that the defendant physician's malpractice insurance carrier deliberately decided "not to provide the defendant with a semblance of a defense." In support of this, the judge cited the fact that the insurance company failed to make an attorney available to the physician for a period of nearly a year and a half. The judge also harshly criticized the defense attorney's poor trial strategy and his failure to prepare either the defendant physician or his expert witness for cross examination by the plaintiff's attorney.

The appellate court in the Bevevino case refused to set aside the jury verdict because it felt that the insurance carrier, rather than the defendant physician, was the real party responsible for paying the $550,000. Since the physician had retired and moved to another state, the court found that he had not been harmed by any effect the adverse verdict may have on his future premium rates. The court suggested that any other harm the physician may have suffered as a result of the verdict could be remedied by his filing suit against the insurance carrier.

This important area of standards of professional care on the part of defense counsel again has been driven home by a recent Illinois case which should be of interest to physicians and other insureds. In the case of *Rogers v. Robson, Masters, Ryan, and Brumond,* 52547 (1980), the Illinois Supreme Court upheld a physician suit for legal malpractice against a law firm which exercised its authority under an insurance policy to settle a professional liability claim without notifying the insured physician. The surgeon alleged that this settlement deprived him of the opportunity to pursue a malicious prosecution suit against the medical malpractice plaintiff and the plaintiff's attorney. He also claimed loss of surgical patients as a result of adverse publicity and suffered an increase in medical malpractice premiums. The requested damages were later reduced from $1 million to $15,000.

The facts reveal that the law firm hired by the physician's former professional liability insurance carrier settled a medical malpractice claim against the physician for $1,250. The policy under which the physician was insured expressly provided that his written consent was not required before the insurer settled. The insurance carrier had interpreted that provision to mean that it could proceed without notifying the insured of its intent to settle. Thus, it settled the claim against the surgeon without giving him notice.

The Illinois Supreme Court said that although the law firm had been employed by the insurance carrier, the insured was entitled to a full disclosure of the intent to settle. The court found that the attorney's duty to make such a disclosure stems from the attorney-client relationship with the insured.

In essence the court ruled that, notwithstanding the existence of an insurance contract under which the insured waives the right to consent to settle, an attorney hired by an insurance company has an ethical obligation to inform the insured of any settlement offers that affect the insured.

This case may not be of great significance to physicians insured by the Medical Inter-Insurance Exchange of New Jersey which requires the insured's consent to settle. However, physicians insured by the New Jersey Medical Malpractice Reinsurance Association have forfeited their contractual right to consent to settlement and, thus, the Illinois case has particular significance for those physicians. The case should be reassuring to all insured physicians since it represents another instance in which a court has determined that insurance carriers and defense attorneys must exercise their best efforts on behalf of the defendant physician. J.E.G.

MEDICAL MALPRACTICE LAW UPDATE

In February, 1980, the Supreme Court of Florida abolished the state's medical malpractice arbitration panels. The court ruled that the institution of such panels to hear medical malpractice cases was "arbitrary and capricious"

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

and, thus, unconstitutional. In the wake of that decision, the Florida legislature enacted a statute effective July 1, 1980, requiring the losing party in a medical malpractice case to pay his adversary's attorney fees. This new rule represents a break from the traditional rule which provides that in most cases each party must pay his own attorney fees.

The new Florida statute applies only in malpractice suits involving physicians, podiatrists, hospitals or HMOs. It is likely that the law will be challenged as having created an "arbitrary" class of litigants in violation of the equal protection clause of the Constitution. The law's drafters anticipated attacks on its constitutionality, however, and wrote a lenghty preamble explaining the legislature's reasons for treating litigants in medical malpractice cases differently from litigants involved in other types of civil litigation.

The new law was supported ardently by the Florida Medical Association and probably will have the intended effect of reducing medical malpractice litigation. An even greater social impact would result if the same rule were applied to all types of litigation as well as medical malpractive litigation. J.E.G.

AMNIOCENTESIS AND INFORMED CONSENT FOR PATIENTS OF ADVANCED MATERNAL AGE*

Physicians have a duty to inform their patients of the risks associated with and the alternatives to any proposed treatment. Regardless of how a physician feels or perceives his or her role, the law is clear that a patient has the right to know and consent to what will or will not be done to his/her body. This right to an informed consent extends to early obstetrical care, in a unique way, with patients of "advanced maternal age." Such a patient must be told about the increased likelihood of chromosomal abnormality and the availability of genetic testing to determine its existence (genetic amniocentesis). The doctor need not perform the test, nor be prepared to perform an abortion if the test later shows a chromosomal abnormality, but the doctor **MUST** inform the patient of the availability of such testing. Moral objections of the doctor as to the suggestion of genetic tests which may lead to an abortion are not legally defensible. The American College of Obstetricians and Gynecologists' *Technical Bulletin* dated May 1976 (Number 39) suggests this information "be made available to all patients over 35 years of age." Once the patient is armed with this information, and the physician has documented his conversation in the record, the *patient* should make the decision as to undergoing the tests or foregoing them. If she decides to undergo amniocentesis, it is the duty of the physician performing the test to advise the patient of the risks involved.

In New Jersey, the case of *Gleitman v Cosgrove* (1967) arose out of the failure of the physician to advise his pregnant patient that her child possibly would be defective when born because she had German measles during pregnancy. The child was born defective. The Supreme Court of New Jersey held that the child could not recover because there were no damages cognizable at law, and that the patient and her husband could not recover because there were no damages cognizable at law and because public policy precluded recovery. Abortion was not a viable alternative, in New Jersey, at the time of this case.

Again, in New Jersey, the case of *Berman v Allen and Attardi* (1978) was argued by the Supreme Court. This case arose out of the failure of a physician in 1974 to advise a 38-year-old pregnant woman of the increased risks of genetic damage to the infant and the availability of amniocentesis. By this time, abortion was a legal alternative to birth, in New Jersey. The position of the defense was that, based on *Gleitman v Cosgrove*, there were no damages cognizable at law and the case should be dismissed. This time, however, the Supreme Court said that although there were no cognizable damages at law for the *child* that the *parents* had a cause of action which they referred to as wrongful "birth" as opposed to a non-existent cause of action for wrongful "life." The wrongful "birth" action would, therefore, accrue only to the parents and only for "emotional damages." The court specifically excluded the cost of raising the child as an element of damages. The case then was retried on the merits. The defense prevailed because they could prove that in 1974 it was **not** the standard to advise 38-year-old pregnant patients of amniocentesis, but it became obvious that if the patient had been older, the decision may have been different.

In February of 1980, the Superior Court in Trenton, NJ awarded a couple $80,000, plus $20,000 interest because the physician, in 1974, failed to advise his 40-year-old pregnant patient of amniocentesis. It had, by this time, become "perfectly clear" that the standard of practice in 1974 was to advise pregnant women 40 years or older of amniocentesis.

In June of 1980, the Medical Inter-Insurance Exchange of New Jersey settled a similar case involving a 42-year-old pregnant woman in the amount of $59,000 twelve days after it was reported to them. Why so fast? *Because it is clear that the failure to advise a 42-year-old pregnant woman of amniocentesis represents a deviation from the standard of practice.* In this case, the insured obstetrician admitted that he did not believe in abortion and went so far as to tell the patient that she would have no problem with another pregnancy. No risks were explained. The child was born with Down's Syndrome.

The Medical Inter-Insurance Exchange of New Jersey has another of these cases pending in which the treating physician's religious or moral convictions have been the element responsible for not allowing patients their right to know.

We all talk about loss prevention. If there is an area where loss prevention could be 100 percent effective, this is it! Physicians who are responsible for the obstetrical care of any woman 35 years or older, **must** tell the patient about and document the possibility of genetic defects, and the availability of genetic counseling. The physician may inform the patient that he will not perform an abortion if the patient makes that election but present standards of care obligate the physician to tell the patient of the risks inherent in becoming pregnant after 35 years of age and the availability of amniocentesis.

DID YOU KNOW

. . . "It seems clear in today's legal climate that successful countersuits will be based on a showing of malice, not negligence. The traditional negligence concept of duty of care does not apply; an attorney's duty of care is to his client, not to his client's adversary."
The Citation, Vol. 41, No. 5, June 15, 1980

. . . "A third of all RNs will leave their profession in midcareer. A recent survey . . . shows . . . the primary reasons listed for dropping out were inadequate staffing, poor administration, *and a lack of communication among nurses, physicians, and administrators. The doctor's office was mentioned most often as the place where communication is likely to break down.*" *Medical Economics*, August 4, 1980

Prepared by Bernard Genest, Director of Claims, MIIE of NJ

EDITORIALS

Physicians and the Nuclear Holocaust

Most physicians, voluntary health agencies, and public health bureaus give lip service to the concept of preventive medicine. Some are involved directly in this tedious, unrewarding, open-ended field of endeavor, but they get little of the immediate or delayed satisfactions of the obstetrician who delivers a healthy baby, the cardiologist who successfully treats a patient with ventricular fibrillation, or the surgeon who cleanly resects a colon cancer. Without fear of contradiction, one can say that, except for a handful of medical and other scientists, none of us in the active practice of medicine has given much thought to the greatest effort of all —obviation of a nuclear holocaust.

"This (the consequences of nuclear weapons and war) is basically a medical problem and the only medical approach to an incurable disease is prevention.

"It is the responsibility of physicians to inform the public about this situation." Dr. Helen Caldicott

For two days, February 9 and 10, 1980, "A National Symposium on the Medical Consequences of Nuclear Weapons and Nuclear War" was held in Boston under the sponsorship of Harvard and Tufts Medical Schools. The meeting was organized by a group called "Physicians for Social Responsibility, Inc." (PSR) This was no assemblage of screwballs and anti-nuclear zealots, but a collection of responsible but alarmed scientists whose composite aim was to inform the public, the medical profession, the Congress of the United States, our national leaders, and other world leaders that a nuclear war will be "our last epidemic."

The speakers at the symposium included Howard H. Hiatt, M.D., Dean of the Harvard School of Public Health; Herbert L. Abrams, M.D., Radiologist-in-Chief at the Peter Bent Brigham Hospital; Carl Johnson, M.D., the Director of Health in Jefferson County, Colorado; Bernard Lown, M.D., Professor of Cardiology at the Harvard School of Public Health; Alexander Leaf, M.D., Professor of Medicine at Harvard and Chairman of the Department of Medicine at the Massachusetts General Hospital; Robert J. Lifton, M.D., psychiatrist and Pulitzer Prize winning author; Salvador E. Luria, Nobel Laureate and Director of the MIT Center for Cancer Research; Dr. Stuart Finch, former Director of Research of the Radiation Effects Research Foundation in Hiroshima, Japan; and many other prestigious scientists.

The symposium brought into focus four basic areas of concern:

1. Nuclear weapons' production
2. Short and intermediate-term effects of a nuclear war
3. Long-term effects
4. Political considerations.

In an editorial summation of some of the ideas, Dr. Henry D. Abraham said:

"We were told that the world is careening toward the apocalypse. The speakers were the nation's most sober and knowledgeable authorities on the subject. We were told that an all-out nuclear exchange would take between one and two hours to complete and would kill 90 percent of the U.S. population within 30 days from blast, burns, and radiation sickness.

"How does one make use of such information? The idea of an end to life on earth transcends our normal frames of reference. The nuclear arms race has placed everything we care about—our families, our crops, our culture, ourselves—in terrible jeopardy. The nature of war now engulfs us all. As a recent essay in *The New Yorker* observed, the tradition in which the soldiers fought on a battlefield to protect the civilians back home no longer applies. In a nuclear war the civilians are all slaughtered and the military operate buttons from remote control stations. A submarine can hide, a city cannot."

H. Jack Geiger, Professor of Community Medicine at City College of New York pointed out that the idea of medical intervention following a nuclear attack on one or more major U.S. cities is ridiculous and a "delusion." For example, he estimates that 2,400 of Boston's 6,500 physicians would be killed on the first day of an attack on that city, that another 2,400 would suffer fatal injuries, and "perhaps 1,000 would survive." Hospitals, transportation, medication and supplies, support personnel and the other meaningful elements of medical intervention would be non-existent. Such an attack would leave Massachusetts with "2 million corpses," but no undertakers.

Dr. Robert J. Lifton, a psychiatrist at Yale, studied the psychological effects of the nuclear attacks on Hiroshima and Nagasaki, and applied some of his findings to *our* thinking on the subject. He characterized our use of the ego defense, *denial,* as a kind of atomic age "psychic numbing," which helps us to go through our daily practice of medicine, hospital rounds, set of tennis or whatever, while ignoring the potential for worldwide annihilation which presently exists.

A major outcome of the symposium was a letter to President Carter and Chairman Brezhnev, which was delivered by Drs. Helen Caldicott, Eric Chivian, Stuart Finch, Jerome Frank, H. Jack Geiger, Howard Hiatt, and Alexander Leaf, and signed by over 700 prominent doctors and citizens.

An Open Letter to President Carter and Chairman Brezhnev

As physicians, scientists, and concerned citizens, alarmed by an international political climate that increasingly presents nuclear war as a "rational" possibility, we are impelled to renew a warning, based on medical and scientific analyses, that:

1. Nuclear war, even a "limited" one, would result in death, injury and disease on a scale that has no precedent in the history of human existence;
2. Medical "disaster planning" for a nuclear war is meaningless. There is no possible effective medical response. Most hospitals would be destroyed, most medical personnel dead or injured, most supplies unavailable. Most "survivors" would die;
3. There is no effective civil defense. The blast, thermal and radiation effects would kill even those in shelters, and fallout would reach those who had been evacuated;
4. Recovery from nuclear war would be impossible. The economic, ecologic and social fabric on which human life depends would be destroyed in the U.S., the U.S.S.R., and much of the rest of the world;
5. In sum, there can be no winners in a nuclear war. Worldwide fallout would contaminate much of the globe for generations and atmospheric effects would severely damage all living things.

Therefore, in the interests of protecting human life, we appeal to you to:

1. Defuse the current tensions between our countries.
2. Ban the use of all nuclear weapons.
3. Recognize the threat posed by the very existence of our enormous nuclear arsenals, and begin dismantling them.

We urge you to meet with us to discuss the medical consequences of nuclear war. We urge all physicians in the U.S. and the U.S.S.R. to join us in this appeal.

As one might predict, both leaders responded to the letter by agreeing in principle with the content of the letter, but neither expressed a willingness to take the steps requested. They both recognized the aims of the PSR as "humane and noble."

What more can we physicians do? We can:

1. Be aware of the danger to world survival.

"Denial, a traditional tool of survival, is precisely the obstacle that blocks our looking at the apocalypse. And worse, each minute that we fail to look, the apocalypse comes closer. Clearly, then, our only hope for survival is to open our eyes and talk freely about the unspeakable." Henry D. Abraham, M.D.

2. Resolve not to accept the inevitability of a nuclear holocaust.
3. Share our knowledge with others in order to "reverse the race toward annihilation."

A.K.

Medical Schools in New Jersey Must Do Their Share*

The discipline of Family Medicine has burgeoned from its modest beginnings in 1969. In that year, family medicine educational programs numbered 15 residencies and a handful of medical school departments. Data from the American Academy of Family Physicians indicate that in 1979, there were 364 approved family practice residency programs. There were departments or divisions of family medicine in over 80 percent of the nation's medical schools. In 1979 and in 1980, slightly over 2,000 United States medical school graduates entered family practice residency programs and the total number of residents in training in 1979 was approximately 6,500.

In New Jersey, the growth of family medicine has occurred in a parallel fashion. In 1969, Hunterdon Medical Center had the only approved family practice residency program in the State. As of late 1979, seven additional residency programs were approved in Hoboken, Summit, Montclair, Edison, New Brunswick and Voorhees. A department of Family Medicine has existed at CMDNJ-Rutgers Medical School since 1973 and in the New Jersey School of Osteopathic Medicine since its inception.

The growth of family medicine during the past ten years has occurred, in the large part, due to its own efforts but it now faces a crucial period in its growth. Forces largely beyond its control are threatening to impede continuing growth and may, in fact, prevent its continued existence. Some of the problems facing family medicine are echoes of problems facing medicine in general while others are specific.

The major problem facing family medicine today is an economic one. It begins with the soaring cost of medical education and the heavily indebted student's unwillingness to enter a "low-paying" primary care specialty. It continues through the unbalanced health insurance system which favors reimbursement for hospitalization over reimbursement for primary care and it critically wounds family practice

*Based on a presentation by Dr. Snope before a meeting co-sponsored by the New Jersey Foundation for Health Care Evaluation and MSNJ's Section on Family Practice, May 12, 214th annual meeting of the Medical Society of New Jersey, Meadowlands Hilton, Secaucus.

graduate education by denying full reimbursement for family practice residency programs. The solutions seem obvious but will require innovative and courageous thinking and action, economic incentives for students who enter primary care disciplines, correction of the imbalanced medical insurance system to favor preventive and ambulatory care and full reimbursement of family practice education by third-party payers in the expectation that the ultimate result will be decreased health care costs.

In New Jersey, a particular problem facing family medicine is attrition. The statistics compiled in the report *"Crisis in Family Medicine"* prepared by the New Jersey Academy of Family Physicians and the data compiled by the New Jersey State Department of Health indicate that over 50 percent of family physicians in the State are 50 years or older. Merely combating attrition will require the production of at least 100 new family doctors per year. Currently, approved residency programs in New Jersey are capable of producing only 46 family doctors per year. The implications are obvious. More students must enter family practice in New Jersey and more residency programs must be organized and developed. In this regard, the medical schools in New Jersey must do their share in the production of family physicians. They need to consider the development of residency programs under their aegis and a program in family medicine which is highly visible to undergraduates. A 1977 study showed that such efforts do result in increased numbers of students entering family medicine.**

A further problem for the discipline of family medicine is that of competition. This is manifested in the sudden awakening of interest in "primary care" by disciplines which have traditionally been more interested in the production of specialists and sub-specialties (e.g., internal medicine). The availability of funding for training programs in "primary care" probably has contributed to this phenomenon. Unfortunately, it has tended to decrease funding for family medicine from federal and other sources. Competition is further evidenced in territorial disputes which occur in medical schools and teaching hospitals over whose responsibility it is to train primary care physicians. This competition is unproductive and ultimately harmful to health care consumers. The solution is simple—reduce the number of specialty training positions available in the United States in favor of increased numbers of positions for family practice. While broad national goals for numbers of family physicians have been proposed by organizations such as the AMA, the complementary goal of reducing the number of other types of physicians has been avoided assiduously by most of organized medicine.

A final problem for family medicine is that of its own credibility. Due to its youthfulness and its overwhelming concern with the development and implementation of its own teaching programs during the past ten years, the issue of a research base for the discipline has been neglected. The family practice setting provides an enormous population with problems for study. The researchable questions for family medicine are many. Family medicine needs to take the initiative and decide in what direction its research efforts will move. On the other hand, funding agencies must be sympathetic to requests for financial support with the realization that research projects in family medicine will fall into epidemiological and behavioral areas rather than into more "typical" research modes.

Family medicine has come a long way in a short time. Some issues beyond its control threaten its existence in the future. Cooperative efforts on the part of state and federal governments, medical schools, and insurance companies and foundations are necessary to address these issues and provide appropriate solutions if the continued existence of the discipline is to be assured.

Frank C. Snope, M.D.

**J.D. Beck, Ph.D., W.L. Stewart, M.D., and T.L. Stern, M.D.: The effect of the organization and status of family practice undergraduate programs on residency selection. *J Fam Prac* 4:663-669, 1977.

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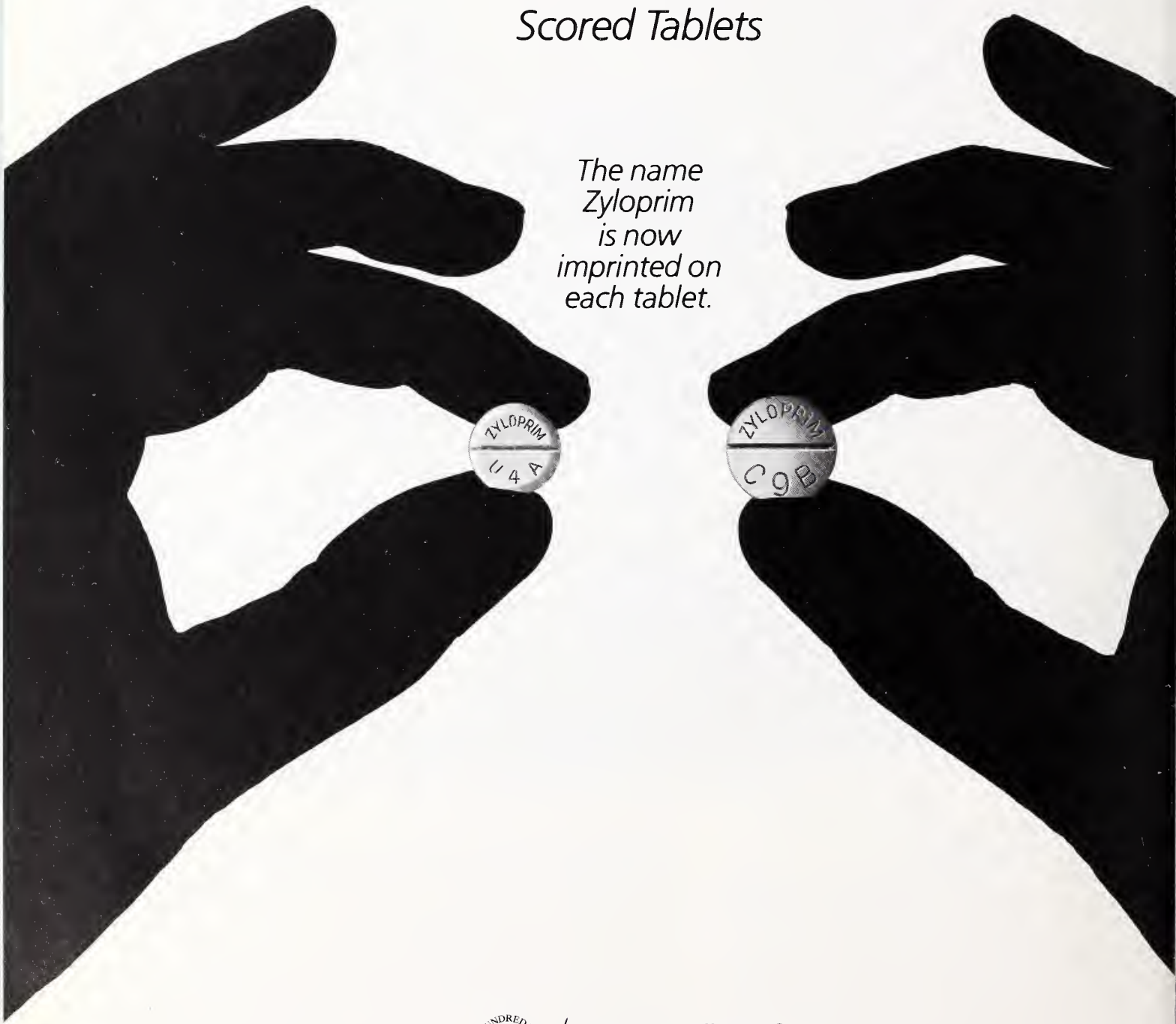

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COMMENTARY

The Forte of the Family Physician (and Some of His Weaknesses)*

Lest anyone think from the beginning that this is an opinionated talk, let me assure you that it is. After a generation of family practice, one is bound to develop certain ideas which resist change. I firmly believe that a good family physician can handle competently 75 percent of the ills that afflict mankind.

Over the past thirty-two years of practice I have made my share of mistakes, but I honestly feel that I have managed the majority of my patients' ailments well—many with simple remedies, others with sophisticated therapies, and some by referral for definitive procedures I was not equipped to perform. Until a decade ago, general practitioners were non-specialized physicians who took care of common medical and surgical problems they felt competent to treat. Now we are training, and certifying as specialists, a group of family practitioners to fulfill a task that needs to be done, but at the same time impinges on the field of other primary care specialties in ways that are causing increasing friction. Primary care, by recent definition, includes family doctors, internists, pediatricians and obstetricians. If we accept broader standards, it also includes psychiatrists. Hence the field of primary care is becoming a competitive one between specialties whose training programs overlap. Family practitioners are being excluded from certain procedures that they had the "right to perform" in the past.

This presentation will discuss some of the strengths and weaknesses of family practice as a viable way of providing the type of health care we need for the latter part of the twentieth century.

I have divided the strengths into four: ongoing care, geriatric care, hospital care and community care.

ONGOING CARE

Without doubt there is no other primary care specialist who can provide the continuity of care that a family doctor can. The internist does not want babies in his practice. Most pediatricians stop treating children when they get beyond adolescence and the gynecologists do not treat male patients. Hence it falls to the family physician to take care of anyone from the day of birth to the hour of death, regardless of sex or emotional stability. One of my patients (an insulin-dependent diabetic who manages his diabetes quite well) considers me a "one-time doctor" who takes care of his needs as they arise.

To some, this continuity of care may seem unimportant, but I'll never forget what an elderly arthritic patient said: "My neighbor told me, 'Why don't you change doctors? You ain't gettin' no better'; but I said to her, 'I think I'll stick with Doc Madara—I ain't gettin' no worse.' "

After accruing thirty-two years of ongoing records, I've learned the value of "growing up" with one's practice. Immunizations can be started at the proper time and updated regularly while unnecessary booster injections can be prevented. A call to your office at the time of an injury or prior to traveling overseas can alert any regular patient as to the need for a special immunization. A record of ongoing medications and especially a list of specific drug allergies is valuable. Those patients who take daily insulin or anticoagulants or biweekly allergy injections realize the need for someone to supervise the dose of and response to these forms of therapy. Often forgotten is the value of an intimate knowledge of a patient's family background in giving important clues to the diagnosis of diabetes, hypertension or emotional instability.

The importance of annual physical examinations has been questioned by some third party payers and federal health planners and more recently by the American Cancer Society. Yet there is nothing that picks up asymptomatic disease like a regular "going over." In this respect most patients treat their cars better than they do themselves. Whether or not any serious disease is discovered in a routine checkup, it still provides a means of keeping in touch with patients' ongoing problems, be they physical, emotional or even financial; and of reminding them of the availability of newer vaccines to prevent such diseases as influenza and pneumococcal pneumonia.

The care of common illnesses, including acute emergency problems, is one of the fortes of the family physician. The daily office routine of a family doctor encompasses the management of hypertension, anxiety, depression, gastrointestinal problems, upper and lower respiratory infections, acute and chronic dermatoses, urinary tract disturbances, and a variety of ailments of the ear, nose and throat. There is no more grateful patient than the one whose deafness is cured by an ear syringe. Those who say that physicians' assistants can handle all these problems do not realize that training without judgment can be as detrimental as self-treatment. The other primary care specialists may have good judgment, but often they are lacking in the basic training required in this field. (An internist on our staff recently told me he wished he knew ears better!) Overtreatment can be as dangerous as mistreatment. Overdosing to lower a patient's blood pressure can have serious side-effects; so can the abuse of antibiotics in the care of common infections.

*Presented by John S. Madara, M.D., before a meeting cosponsored by the New Jersey Foundation for Health Care Evaluation and MSNJ's Section on Family Practice, May 12, 1980, 214th annual meeting of the Medical Society of New Jersey, Meadowlands Hilton, Secaucus.

Whether we like it or not, drug and alcohol problems often are relegated to family practice by default. Unfortunately, the time required for their solution mandates the use of a number of ancillary services—psychiatric, rehabilitative, even punitive. But, in this area, it often behooves the family doctor to be the captain of the ship.

This leads to the value of the family practitioner in many realms outside his office practice: for example, as consultant for industry, jails, schools, and insurance companies. Many a new general practitioner finds that an appointment as industrial physician, school doctor, county coroner or medical examiner provides a welcome remuneration as well as a pleasurable avocation.

One of the strengths of the family physician is the followup of patients after discharge from the hospital. So often the care of other specialists ends when the patient goes home, and it becomes the privilege and duty of the family doctor to carry on from that point.

A word about the controversial problem of house calls. I truly feel the family physician of the future will be willing to make more home visits, especially to the elderly who have trouble getting around, the stubborn who won't leave home, and the disabled who can't. These are legitimate reasons for a house call, and deserve proper remuneration, but I rarely see the justification for a home visit to examine an able adult, a sick child or an injured patient who can walk.

GERIATRIC CARE

This is a responsibility that falls to the family physician by default. A decade or two ago we heard about the evolving specialty of geriatrics or gerontology. How many pure geriatricians are there? If the truth be admitted, it is too depressing a specialty for a full-time participant. The end result, in spite of the quality of treatment, is always death, even though the road may be a winding one fraught with a variety of complications. It is these medical problems, often simple, but occasionally prolonged, which are handled effectively by family doctors: bed sores, urinary tract infections, sleep disorders, dietary vagaries, behavior problems, and the gamut of emotional maladjustments from anxiety to depression, from maniacal heights to suicidal depths. Most of those in nursing facilities and boarding homes are cared for by family practitioners, mainly because no one else wishes to do it. Many surgeons and internists write on hospital charts "discharge to nursing home" with no desire to see the patient again until he is readmitted. It behooves us as ongoing practitioners to pick up the gauntlet and see that these patients receive good followup care.

HOSPITAL CARE

This is an area that is becoming more limited as time goes on—that is, the domain of the family physician on the active medical staff. Does it not seem logical that a doctor who is trained to care for the common illnesses of his patients should be allowed to carry on the management of these patients in areas in which he is competent? Who else could better clear his patient for anesthesia and surgery? Why should he not be allowed to treat common pediatric problems in a hospital setting? Can he not perform a good newborn examination and care for babies in a nursery? And shouldn't he be able to handle one of his patients with delirium tremens or diabetes or an uncomplicated heart attack or stroke?

It seems evident that the intimacy of the patient-family doctor relationship, and that doctor's knowledge of his patient's reaction to other physicians, makes him an excellent judge of the type of specialist to call, the choice of consultant and even what diagnostic tests are useful without ordering a battery of unnecessary procedures. Furthermore, his knowledge of a patient's drug allergies, or a person's response to previous illnesses or operations, or the reaction of his family to former episodes of sickness are invaluable in the successful outcome of any hospitalization.

COMMUNITY CARE

The fourth area where family physicians can be beneficial in the overall health scene is one of extracurricular concern—a mixture of things he often does without benefit of monetary reward, but which mean much to the community in which he lives. Family doctors often serve well on local boards of health, professional standards review organizations, school boards, and health systems agencies because they offer a wider perspective than some of the super specialists. A family doctor with teaching skills often is asked to participate in public health seminars, community talks, emergency courses in cardiopulmonary resuscitation, training of residents, nurses and paramedical personnel. The ability to teach often is discovered when a family physician is asked to share his time on a radio program or television show. Some family doctors have a knack for family counseling, and do it better than a structured mental health clinic, because of their intimate knowledge of all the family problems. The role of the family physician as a member of a hospital staff committee, a hospital board of trustees, and even as a chief-of-staff cannot be underestimated.

THE WEAKNESSES

Now let's flip the coin and look at the tails' side. Some of the weaknesses to be discussed are those of any physician who does clinical practice; others are specific for family doctors. Let's mention the latter first. One of the definitions of a generalist is "a doctor who knows less and less about more and more until he eventually knows nothing about anything." There is always the temptation for those who have received a broad medical training to overestimate their ability to do special procedures. It is in these areas that the family physician comes into conflict with various specialties and it is in these very areas that he must prove his competency before being allowed certain privileges, for example, in surgery, obstetrics, pediatrics and cardiology. No family doctor is competent to be "all things to all people."

Another temptation besetting family physicians is the wish to subspecialize in questionable areas of need which may be very lucrative, such as weight-control programs, laetrile protocols, and injection therapies of all types—from intramuscular B-12 to intrathecal steroids.

A real detriment to high-quality family practice is the large patient-load of most generalists. Very few family physicians in established practice say they're looking for new patients; most say they are overworked. Because of this their availability suffers and they have less time for teaching students, attending to necessary correspondence and filling out the numerous governmental, insurance and third party forms. This busyness, of necessity, affects any physician's availability. It is neither physically possible nor morally mandatory for any solo practitioner to be on duty twenty-four hours a day, seven days a week. But, one of the weaknesses of a busy family doctor is the unanswered telephone call, the uncovered day off, and the long vacation without a substitute. The family physician of the future must learn to take

advantage of a good answering service, a covering cohort or a willing emergency room group to make sure his patients know where to go and what to do when he is not available.

A weakness that is not necessarily limited to family physicians, but one to which he is often prone, is the desire for rapid and permanent therapeutic results—hence, the temptation to use an overdose of a good drug, or a prolonged dose of a dangerous drug. There are optimal doses for most drugs, and more is not always better. Unfortunately, drugs taken by out-patients have no automatic stop orders. It also seems reasonable not to use a potentially toxic drug when a less toxic drug will work as well. Often the adverse reactions of dangerous drugs go unheeded—and sometimes until it's too late. As frightening examples, witness the aplastic anemia caused by chloramphenicol, the permanent tooth-staining caused by tetracycline, and the enterocolitis caused by lincomycin. We need to be reminded continually of these tragedies.

Lastly, a word about the importance of followup after office visits, which applies to all physicians, but particularly to those who work by appointment. One of the responsibilities of a physician to his patient is to give followup reports on specific tests—such as electrocardiograms, Papanicolau smears, prothrombin times and blood sugars—either by telephone or by letter. A practitioner who is weak in this area may be more prone to liability and find that patients do not return.

One final word about appointments: patients have a personal responsibility to keep them, but physicians, barring an unforeseen emergency, have an ethical responsibility to be there.

SUMMARY

There are strengths and weaknesses in any profession. I have tried to point out that family practice, as a means of providing a continuity of ongoing care (including geriatrics), of furnishing good non-specialized hospital care and of adding value to a variety of community programs, has stood the test of time and will guarantee a flourishing future for this twentieth specialty.

Dr. Ward Donovan, head of the emergency medical division of Hershey Medical Center, recently told of the residents in the Three Mile Island area who looked to their family doctors for advice and example. In areas where the doctor left home, the whole block would leave with him.

The weaknesses of family practice are those of the profession in general, with specific deficiencies which can be corrected by those who strive for excellence. Sir William Osler once said of the family doctor:

"In no profession does culture count for so much as in medicine, and no man needs it more than the general practitioner."

Let me end by quoting what he told the graduating medical students at McGill University almost seventy-five years ago:

"With an optimistic temperament and a good digestion he is the very best product of our profession, and may do more to stop quackery and humbuggery, inside and outside of the ranks, than could a dozen prosecuting county attorneys. Nay, more! Such a doctor may be a daily benediction in the community—a strong, sensible, whole-souled man, often living a life of great self-denial, and always of tender sympathy, worried neither by the vagaries of the well nor by the testy waywardness of the sick, and to him, if to any, may come (even when he knows it not) the true spiritual blessing —that 'blessing which maketh rich and addeth no sorrow.' "

To all who heed these words, I wish you that blessing!

John S. Madara, M.D.

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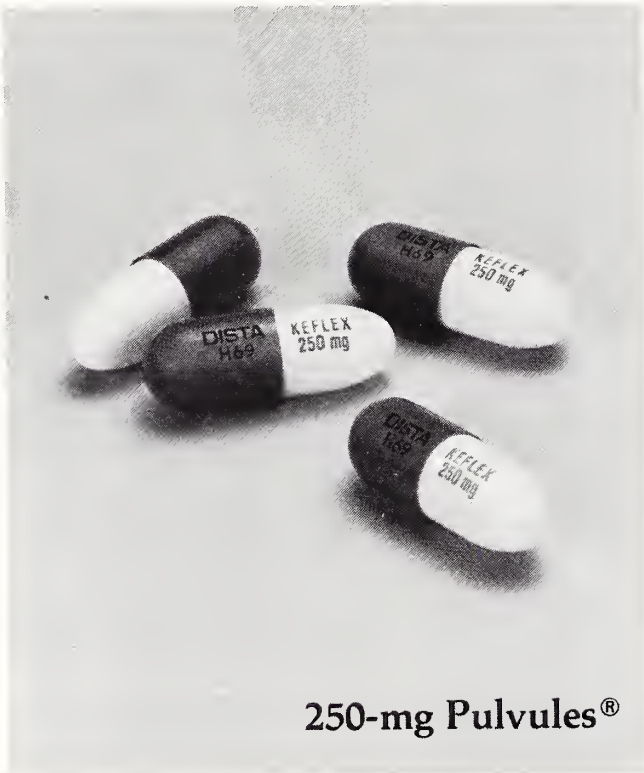

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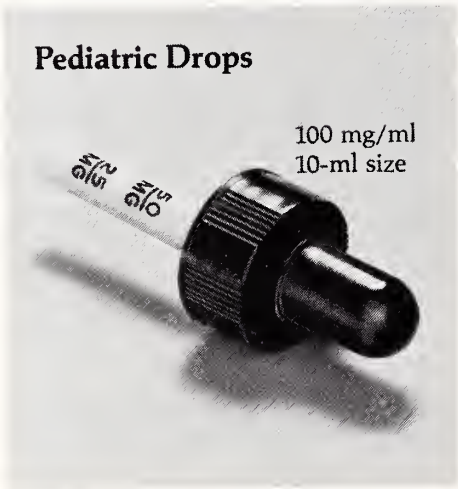

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JEMPAC REPORTORIAL*

VULNERABILITY

Defeat can be snatched from the jaws of victory via vulnerability. What is vulnerability? It is that one item which is usually peculiar to one district and one race and is hard to define. It may be that the candidate is vulnerable because he is *too* senior, and has a vigorous, youthful opponent who uses the incumbent's seniority and age against him. It may be that the candidate is vulnerable because he has some family or personal problems which have been given publicity and have diminished his image in the public's eyes. It may be that his party's registration has dropped sufficiently so that he must overcome a numbers obstacle. Or, some national event may occur which becomes *the* issue the public is concerned about, and your candidate is on the least popular side of the issue. Other occurrences which might make a campaign vulnerable are unfavorable redistricting, local scandals which reflect on the candidate's party, and the diminishing of party organization. Vulnerability is a difficult campaign aspect to evaluate, but it is usually the most obvious aspect to the evaluators familiar with the district. In other words, the candidate's vulnerability, if he has it, will be most obvious to his supporters as well as the opponent's supporters, and therefore, is an even bigger factor because of its obviousness.

But what if you evaluate your candidate, and he turns up a loser? Your only alternative is to support the candidate with which you least agree. Right? Wrong!

There are circumstances which would make it worth your while to be involved in a "losing" campaign. Suppose the incumbent is anathema to you and your like-minded friends. But he is firmly entrenched in office and no challenger will oust him. However, there is a challenger who would have an excellent chance should the incumbent retire, resign or stumble badly enough to jeopardize his election. Long-range goals should prompt you to support the challenger. This is building for the future. Also, supporting the challenger keeps the incumbent on his toes, forces him to use his financial resources, keeps him working, and often forces him to be more attuned to his constituents.

A friendly incumbent whose election is assured should be evaluated in terms of long-range goals. Again, investing in his campaign keeps the opposition from eroding his victory margin and it prevents *"them"* from building a challenge for the future. Giving a friendly incumbent a wider margin of victory gives him confidence among his peers, improves his leadership status in the Congress or State Legislature and in his party.

VOTER APATHY

"Jimmy Carter became President of the United States despite the fact that 73 of every 100 Americans of voting age did not vote for him.

"When Governor Brendan Byrne of New Jersey ran for reelection in 1978, fewer than 15 percent of those eligible voted for him, but that was enough to win.

"Ed Koch was elected mayor of New York City by fewer than 12 percent of 'Big Apple' voters. . .

"Not only are tens of millions of Americans not voting, but more than 15 million eligible citizens who used to vote regularly have simply stopped altogether." *Nation's Business,* March 1980.

BE CERTAIN YOU HAVE REGISTERED TO VOTE AND THEN EXERCISE YOUR AMERICAN RIGHT!

PROFILE OF A VOTER

"What kind of Americans are most likely to vote?

"The Bureau of the Census made an in-depth study of voters in the 1978 congressional elections and came up with these answers:

"(1) Homeowners are twice as likely to vote as renters—59 percent and 28 percent, respectively.

"(2) People who have lived in the same house for a long time vote more than those who have recently moved.

"(3) Married couples with families are more likely to go to the polls than other relatives living in their households and twice as likely as nonrelatives.

"(4) College graduates are more than twice as likely to vote as those who did not complete elementary school—64 percent and 29 percent, respectively.

"(5) White-collar workers vote more than those in other occupation groups.

"(6) People 65 years and over are nearly three times as likely to vote (56 percent) as 18 to 20 years olds (20 percent)." *Nation's Business,* March 1980."

MSNJ'S POSITION ON PROPOSED NJ LEGISLATION

Information regarding MSNJ's position on various proposed legislation will be presented in each "Reportorial." We urge you to write to the sponsors, the committee, and committee members to make MSNJ's views known, c/o State House, Trenton, NJ 08628.

Senator—398—John E. Russo (9th District, part of Ocean, Burlington, and Monmouth). To extend "implied consent" to the taking of either blood or urine for the purpose of making tests to determine the existence and content of drugs and alcohol in a driver's system. *APPROVED.* Referred to:

Law, Public Safety and Defense Committee:

Frank X. Graves, Chairman, Francis Rodgers, Vice-Chairman, John Caufield, Walter Foran, Barry Parker.

Assembly—1247—Carl A. Orechio (27th District, part of Essex).

To prohibit a physician to charge certain individuals for surgery in excess of the patient's health insurance contract. *ACTIVE OPPOSITION,* because the bill is to all-inclusive; it is unclear, and puts a burden on the physician of determining insurance coverages. Referred to:

Banking and Insurance Committee:

James W. Bornheimer, Chairman, Charles Mays, Vice-Chairman, Michael F. Adubato, Thomas A. Gallo, Louis F. Kosco, Carl A. Orechio, Frederic Remington.

Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

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The Non-Invasive Assessment of Carotid Artery Disease

WILLIAM A. ROUGH, M.D., BRUCE J. BRENER, M.D.,
JOSEPH ALPERT, M.D., DONALD K. BRIEF, M.D.,
ROBERT J. GOLDENKRANZ, M.D., VICTOR PARSONNET, M.D.,
ALLAN C. TIRO, M.D., LARRY A. SCHER, M.D., Newark

A review of the currently available techniques for non-invasive examination of the carotid artery is presented with a discussion of the physiologic principles and inherent flaws of each technique. The authors' experience with 503 patient examinations using phonangiography, directional Doppler ultrasound, pneumo-oculoplethysmography, and fluid-oculoplethysmography is reported with five illustrative case presentations. When compared to arteriography, the combined diagnostic accuracy of the four examinations is 89 percent in our institution.

The early identification of patients who might benefit from carotid endarterectomy is the primary goal of the non-invasive vascular laboratory. Stroke, the third leading cause of death in the United States, is better prevented than treated. It has been estimated that 75 percent of patients presenting with stroke symptoms have at least one surgically accessible extra-cranial vascular lesion.[1] Carotid endarterectomy has been shown to be effective low-risk therapy for stroke prevention in selected patients with extra-cranial cerebrovascular disease.[1-3]

The ideal non-invasive screening study should be inexpensive, inoffensive to the patient, efficiently performed by non-physicians, reproducible, accurate, easily interpreted, and free of complications. It should identify lesions before they become clinically evident. This review describes the available screening procedures and compares them to the diagnostic standards of arteriography. An analysis of the Newark Beth Israel Medical Center experience with over 500 patient evaluations also is presented, including five illustrative case reports.

NON-INVASIVE SCREENING PROCEDURES

Each patient should be given a routine evaluation consisting of a thorough history, a complete physical examination, and basic laboratory studies prior to referral for non-invasive testing. This serves to narrow the differential diagnosis as well as to identify those patients with conditions which may adversely affect or contraindicate the planned examinations.

Phonangiography—A change in vessel lumen diameter or surface regularity by atherosclerotic lesions will produce turbulent flow which may be palpable as a thrill or audible as a bruit. The bruit may be converted to an electrical impulse by a microphone, displayed on an oscilloscope, and permanently recorded on film by an attached camera. Sophisticated spectral analysis of the frequency content of a bruit permits a quantitative estimation of the most severe stenoses and differentiates carotid murmurs from transmitted murmurs of cardiac origin.[4,5] Carotid phonangiography fulfills most of the criteria demanded for the ideal study. However, the test is ineffective when used to investigate lesions which do not produce a bruit, such as an ulcerated plaque or a total occlusion of the carotid artery. Also, it is unable to differentiate between bruits originating from the internal or external carotid arteries and it provides no information concerning the status of the distal circulation.

Directional Doppler Ultrasound—Significant internal carotid stenoses will result in a reversal of flow in the terminal branches of the ipsilateral ophthalmic artery when the external carotid system provides collateral circulation to the

*This report is from the Stephen Schaffan Non-Invasive Vascular Laboratory—Department of Surgery, Newark Beth Israel Medical Center, and the Department of Surgery, College of Medicine and Dentistry of New Jersey, Newark, N.J. Correspondence may be addressed to Dr. B.J. Brener, Department of Surgery, Newark Beth Israel Medical Center, 201 Lyons Avenue, Newark, N.J. 07112

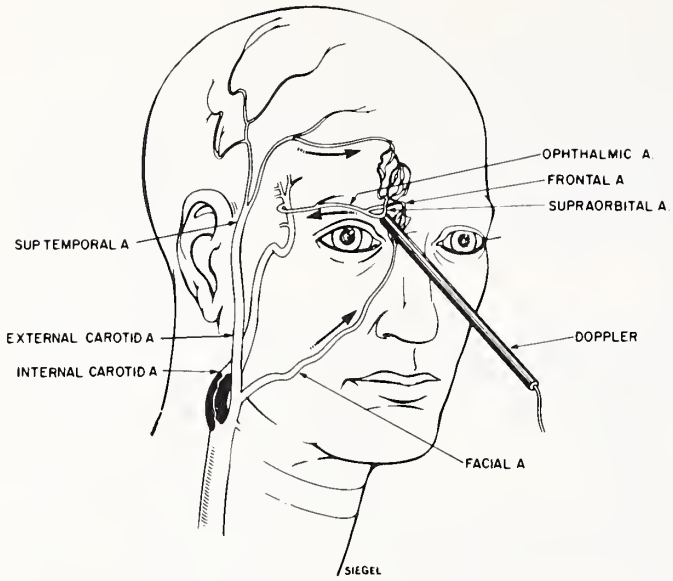


Figure 1—With a significant stenosis of the internal carotid artery, retrograde flow in the ipsilateral ophthalmic artery may be detected by a direction sensing Doppler probe positioned over the supra-orbital artery.

brain. The superficial temporal artery anastomoses with the supraorbital artery and the facial artery with the frontal artery to form the collateral pathways. With internal carotid stenosis, the direction of flow in the supraorbital, frontal, and ophthalmic arteries would be retrograde, i.e., toward the Circle of Willis as depicted in Figure 1. Flow reversal in the supraorbital and frontal arteries is identified by a directional Doppler probe. Sequential compression of the branches of the external carotid artery will result in diminished flow through the frontal and supraorbital arteries.[6] Ipsilateral and contralateral carotid compression tests have been advocated by certain investigators to identify those patients with carotid disease whose directional flow is normal because of intracranial collateral circulation.[7] Addition of the compressive maneuvers reportedly increases the accuracy of this study to 98 percent for lesions occupying greater than 75 percent of the vessel lumen while the risk of cerebral insufficiency following carotid compression is reported to be less than 0.1 percent.[7] The test is less accurate for stenosing lesions in the 60 to 75 percent range.[8] The directional Doppler is unable to identify ulcerative or non-ulcerative stenoses of less than 60 percent and gives no information as to the status of the distal internal carotid circulation. Occasionally, directional flow in the opthalmic artery will be normal in spite of carotid stenosis because of collateral circulation from other sources. Concomitant external carotid lesions further may complicate interpretation of the results.

Fluid Oculoplethysmography—Fluid oculoplethysmography (F-OPG) is performed by placing transparent cups on the anesthetized cornea with 40 to 50 mmHg suction. Bilateral ocular pulsations representing the volume changes of each globe produced by pulsatile arterial flow are recorded simultaneously for comparison. Light opacity sensors on the ear lobes provide concomitant pulses from the external carotid circulation. A delay in the timing of one ocular pulse relative to the other suggests ipsilateral internal carotid disease. Bilateral disease may be detected by delay in both ocular pulses relative to the ear pulse.[9] The test satisfies most of the criteria of the ideal non-invasive screening study described above. However, accurate interpretation of the waveform is not always easy and requires experience for accuracy. Complications are rare, consisting primarily of

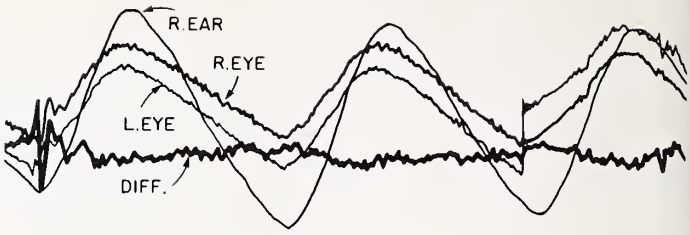


Figure 1A—A normal fluid oculoplethysmography. Note the nearly horizontal differential tracing and the parallel alignment of the eye tracings.

minor corneal abrasions or conjunctival hemorrhage which promptly heal with appropriate therapy. In addition, a small number of patients (less than one percent) may be unable or unwilling to cooperate sufficiently to allow the test to be performed. Kartchner reports an approximate 95 percent accuracy of the test when combined with phonangiography, while McDonald estimates 86 percent accuracy when used alone to identify stenoses greater than 60 percent.[8,9,10]

Pneumoplethysmography—Ocular pneumoplethysmography (P-OPG) as described by Gee uses an airfilled system rather than the fluid system discussed previously. The cup is placed on the anesthetized sclera. The vacuum pressure exerted on the orb is -300 mmHg which produces a maximum intra-ocular pressure of 110 mmHg. During the gradual decline of intra-ocular pressure, the point at which the pulsatile flow returns, as depicted by a wave reflection on a recorder, is equal to the systolic pressure of intra-cerebral blood flow.[11] This reflects the pressure in the internal carotid artery. A difference of five mmHg between the right and left retinal artery pressures is considered significant.[12] In addition, a test is considered positive when there is a difference in the eye pulse amplitudes of two mm or more at 110 mmHg. In cases of bilateral disease, the difference between the two ophthalmic artery pressures may not be significant; however, if the ophthalmic artery pressure/systolic brachial pressure index is less than 0.66, the test is also positive.[8,12,13,14] Using these three criteria, the test is nearly 100 percent accurate in detecting complete occlusions or pre-occlusive stenoses (greater than 90 percent); it is less successful in diagnosing stenoses of 60 to 90 percent[8,12,13,14] The test is more precise when limited to patients whose retinal artery pressure does not exceed 110 mmHg, although a new device has been developed which will raise the suction pressure to -500 mmHg thereby increasing the applicability of the P-OPG. Trauma to the sclera and conjunctiva are rare. A history of retinal detachment, glaucoma, recent ophthalmic injury, surgery, or infection are contraindications to the P-OPG examination.

Ophthalmodynamometry—Ophthalmodynamometry (ODM) is similar in principle to the P-OPG test but requires ophthalmoscopic visualization of the cessation of pulsations in the retinal artery with increasing intra-ocular pressures. The test suffers from examiner variability and presents no permanent record of the examinations.[15,16]

Photoplethysmography—Supraorbital photoplethysmography (PPG) examines blood flow through the supraorbital artery in much the same fashion as the directional Doppler study described earlier but the ultrasonic Doppler is replaced by a photo-electric emission and detection system. The infrared light waves are back-scattered by the tissue microcirculation and the received impulses are converted to a plethysmographic tracing on the recorder. Results are essentially equal to the directional Doppler studies, although

Table I
Patient Population and Results of Non-Invasive Carotid Testing

Indication	Number Treated	Number Positive	Percentage
1. Routine Screening	148	8	5
2. Asymptomatic Bruit	29	9	30
3. Non-hemispheric Symptoms	116	23	20
4. Hemispheric Neurological Symptoms	166	54	33
5. Miscellaneous (post-endarterectomy, neck or ear pain, headache)	44	12	25
Total:	503	106	21

patients with previous forehead trauma (such as lacerations), may have a false-positive study with the PPG.[17]

Thermography—Blood flow through the supraorbital artery may be measured indirectly by thermography; coolness of one supraorbital region as compared to the other presumes proximal disease. The test suffers from the usual thermographic difficulties of increased temperature due to local factors such as inflammation and trauma or systemic fever. The test is qualitative in nature and gives no indication as to the location of the proximal disease. Thermography is positive in 88 percent of the patients with significant stenoses or occlusions in the proximal carotid circulation.[18] It is time-consuming, however, and probably not economically feasible for mass screening.[19] Using thermistors to record the forehead skin temperature will increase the accuracy of thermography and is considerably less expensive; however, it remains an indirect method of measurement of supraorbital blood flow.[20]

Newer Methods of Examination—The previously described examinations are unable to diagnose either minimal stenoses (less than 50 percent) or non-stenosing ulcerated plaques. Sophisticated techniques of Doppler signal analysis currently are being employed in an attempt to identify these minimal lesions. Spectral analysis of the continuous-wave Doppler shifted signals will produce a sonogram which permits an estimation of erythrocyte velocity and the general flow pattern, laminar or turbulent, in a specific section of the artery. Unfortunately, this method is still unreliable in the detection of stenoses of less than 50 percent.[21] Attachment of a position-sensing arm to a directional Doppler probe allows the signal to be transmitted to a storage oscilloscope, producing an image of the scanned vessel after repeated passes of the probe.[22] Ultrasonic angiography is a two-dimensional image of flow through the vessel; it provides a physiologic picture while x-rays provide anatomic detail. Spectral analysis sonograms have been combined with imaging to better evaluate the flow patterns; clinical trials are now in progress.[23] The echoflow imaging Doppler displays regions of stenosis by different colors which are coded to the altered energy shifts reflecting the flow distributions created by the stenoses. Ninety percent of stenoses which narrow the lumen by 75 percent or greater were identified correctly and located with this instrument.[24]

The pulsed Doppler also has been utilized in sonographic and imaging systems. The emission of a pulsed time signal has the advantage of isolating an examination at any desired depth. Scanning with a pulsed Doppler will permit cross sectional as well as longitudinal imaging. Also, by focusing a small beam of sound at a specific depth within the vessel, better resolution of the lumen is obtained.[25] Unfortunately, the resolution of both continuous wave and pulsed systems has not been sufficient to identify minimal lesions consistently. Also, calcifications in the wall will not be penetrated by either instrument, thus providing a negative "sonar shadow" which may hide a stenotic lesion.[26]

The pulsed Doppler signals also have been subjected to extensive sonographic analysis.[27] The use of multiple channels spaced at one millimeter intervals across the lumen permits evaluation of the velocity profile and hence, flow patterns: a parabolic pattern in pure laminar flow or a more even distribution of energy in turbulent flow. The location of arterial lesions can be determined by recognizing the abnormal patterns in the sonograms. The sensitivity of this method also requires a reduction in intra-luminal diameter by 50 percent or more to produce the abnormal flow patterns.

An ultrasonic Duplex Doppler which contains both B-mode and pulsed transducers recently has been introduced. The imaging is used to visualize lesions and also serves as an anatomic reference for the assessment of velocity changes. The velocity changes may be interpreted using realtime spectral analysis. The early results of this instrument indicate an accuracy of 78 percent for stenoses of less than 50 percent.[28]

Use of a multi-channel pulsed Doppler permits the calculation of the blood velocity from the Doppler formula:[29]

$$V = \frac{FC}{2 f_o \cos \Theta}$$

where: F = frequency shift
C = speed of sound in tissue
f_o = transmitted frequency
Θ = angle of incidence of the sound beam with the vessel

The difficulty lies in an accurate determination of the angle of incidence, Θ. If Θ were known precisely and the spacing of the channels also were known, then the cross-sectional area of the arterial lumen could be calculated. The product of the velocity times the cross-sectional area equals the flow rate at that particular portion of the vessel. Measurements of flow rates at various levels along a vessel could identify lesions before they become significant and could be used to follow patients sequentially.

A combination of a 30-channel pulsed Doppler with an imaging system has been used to estimate the angle Θ and thus to calculate flow rates.[30] This system, using cross-sectional images approximately one mm apart, permits an estimation of the vessel axis. The angle Θ is the angle of incidence between the orientation of the sound beam from the position resolver and the estimated vessel axis. The measured velocities are arranged over eight cardiac cycles to

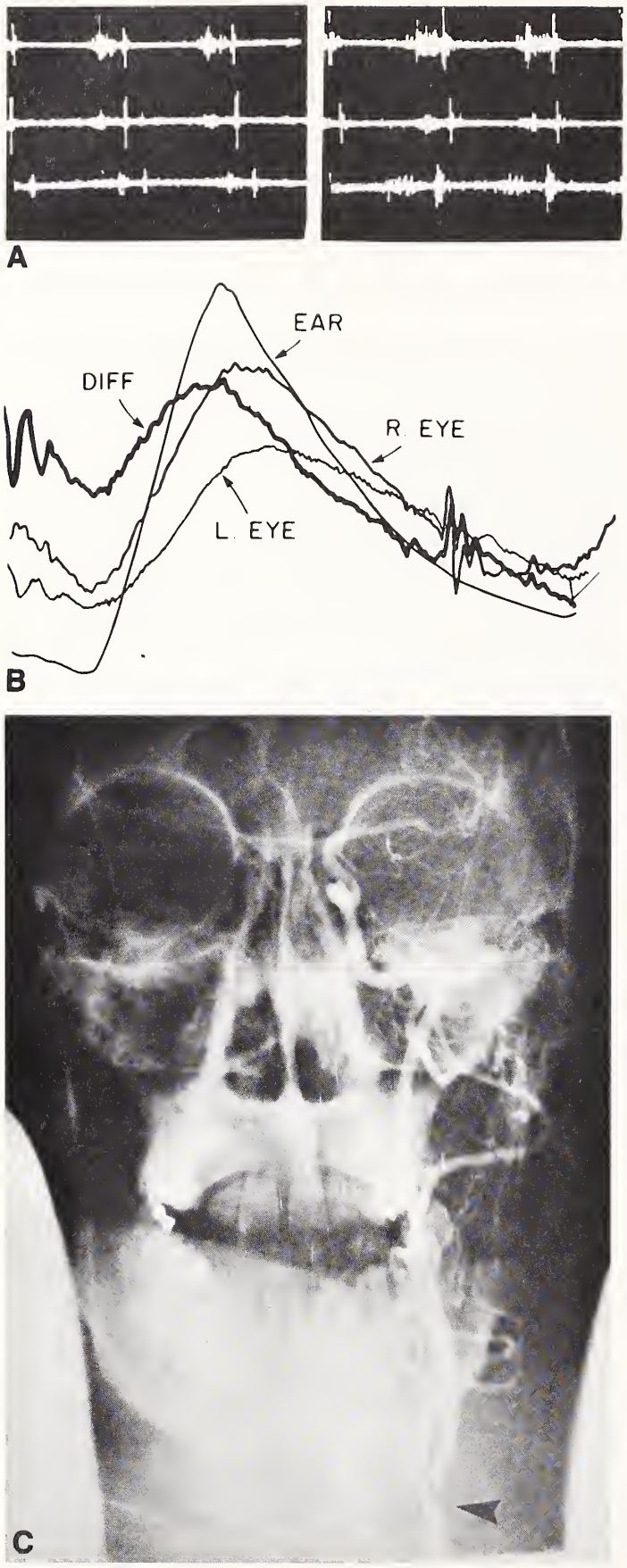


Figure 2—(Case #1) The phonangiogram (a) depicts a low-grade left-sided bruit and the fluid-OPG (b) demonstrates a marked delay in the left ocular impulse. These findings are compatible with a high-grade stenosis of the left internal carotid (c) at its origin (arrow).

give the mean flow rate in the final calculation. However, even in this sophisticated system, the angle of incidence is still being estimated and not measured. Because the angle is used to calculate both the velocity and the intra-luminal area, it must be known exactly to determine the flow rate precisely. Clinical experience has not been reported as yet with this newly developed technique.

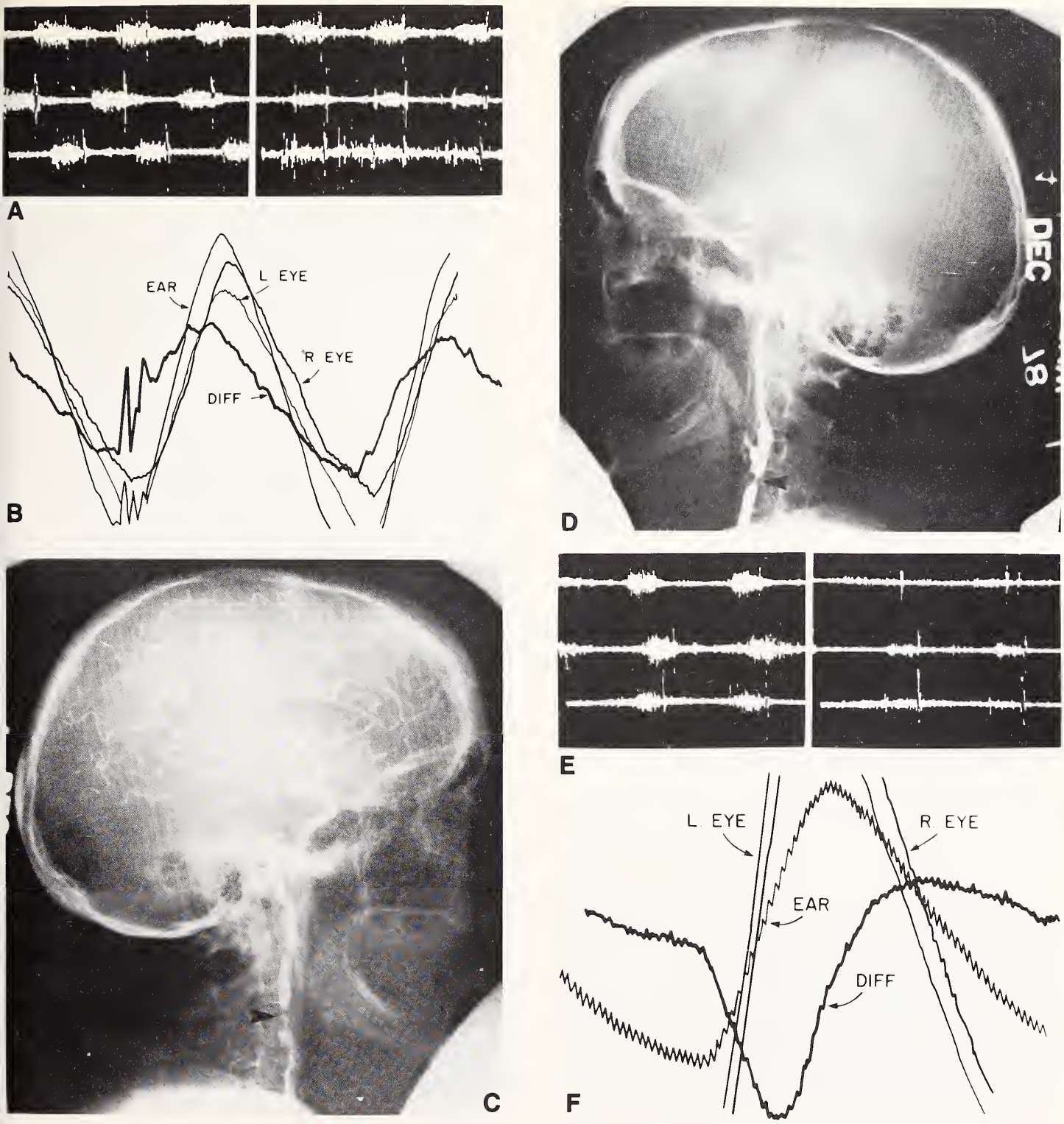
These sophisticated instruments are not yet ready for widespread clinical use. There have been few clinical trials and most of the instruments are expensive. The presently accepted methods of examination have proved their value when used appropriately and interpreted carefully.

NEWARK BETH ISRAEL MEDICAL CENTER (NBIMC) EXPERIENCE

At the Stephen Schaffan Non-Invasive Vascular Laboratory at NBIMC, four systems are used to evaluate the carotid artery: phonangiography, directional Doppler, F-OPG, and P-OPG. From January 1977 to July 1978, 503 patient examinations were performed. Patients referred for carotid testing were classified by symptoms into five groups (Table I). The routine screening group (Group I) consisted of patients about to undergo cardiac surgery who had no neurologic complaints or bruits on physical examination. As expected, this group had the lowest yield of positive examination, five percent. This is a substantial number of patients, however, indicating a high-risk group. Not surprisingly, the patients with an obvious neurologic history (Group IV) had the highest percentage of positive examinations—33 percent; however, those patients (Group II) with an audible bruit, lacking a positive neurologic history or findings, had an almost equal percentage of positive studies—30 percent. Groups III and V consisted of patients with symptoms less reliably related to carotid artery disease; consequently, their yields were intermediate—20 percent and 25 percent respectively. The following case reports illustrate the uses of the non-invasive laboratory examinations for the various patient groups.

Case #1—(Figure 2) A 62-year-old male was admitted for elective coronary artery bypass eight months after suffering a myocardial infarction. Physical examination revealed no neurologic deficits or carotid bruits. Routine non-invasive screening test revealed a low grade bruit by carotid phonangiography (CPA), a marked delay in the left ocular impulse on F-OPG, a reversal of flow through the supraorbital artery by directional Doppler. On P-OPG, the left ophthalmic pressure was 98 mmHg and the right was 108 mmHg. The patient underwent angiography which demonstrated a greater than 95 percent stenosing lesion of the left internal carotid artery and minimal disease on the right side. The next day simultaneous left carotid endarterectomy and a triple coronary bypass were performed. The patient made an uneventful recovery and has been well since discharge.

Comments—This patient, although completely asymptomatic, was discovered through routine non-invasive screening to have the severe left carotid stenosis depicted arteriographically in figure 2. He was considered to be at risk to suffer complete carotid occlusion or stroke during the anesthesia and periods of hypotension associated with cardio-pulmonary bypass. Therefore, concomitant operations were advised.[31] The CPA reproduced in Figure 2 demonstrates a holosystolic, low amplitude bruit compatible with a greater than 85 percent stenotic lesion producing turbulence at a greatly reduced flow velocity. The F-OPG tracing in Figure 2 depicts the left ocular pulse delay as compared to the right eye tracing; the delay is easily apparent from the deflection of the differential curve representing the difference of the amplitude of the right and left ocular tracing at any instant in time. When the differential trace is skewed upward, a left ocular delay is detected.



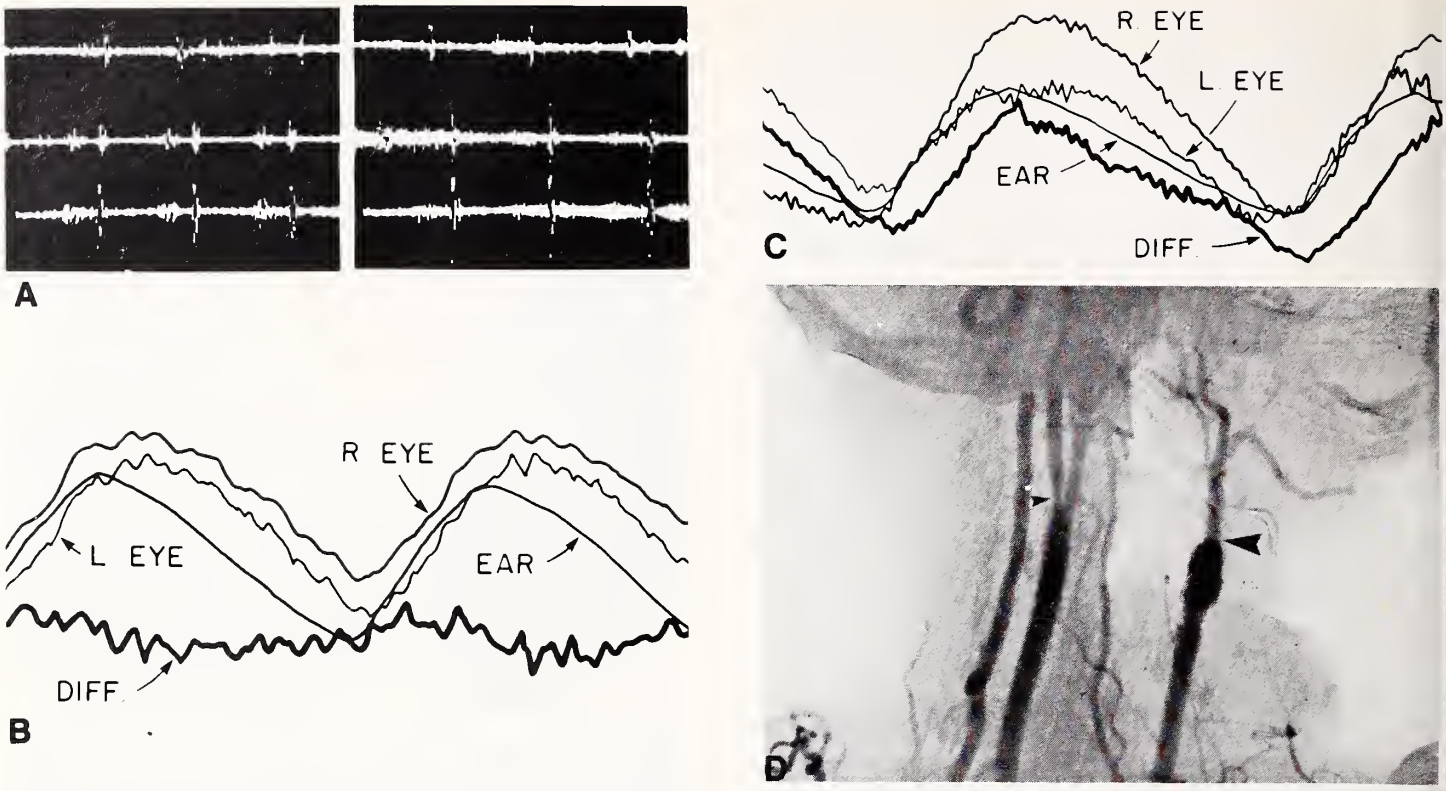
Figures 3—(Case #2) The phonangiogram (a) demonstrates bilateral bruits and the fluid-OPG (b) is positive for a left ocular delay. Arteriography clearly shows the right carotid stenosis (c) and the narrowing of the previous endarterectomy site on the left (d). After correction of the left carotid stenosis, the phonangiogram (e) depicts only the right-sided bruit remaining and the F-OPG (f) clearly demonstrates a right ocular impulse delay.

Arteriographically, the percent stenosis is obtained by the following formula:[32]

$$1 - \frac{\text{Stenotic Lumen Diameter}}{\text{Normal Lumen Diameter}} \times 100 = \%\ \text{Stenosis}$$

The normal lumen diameter is distal to the stenosis, not at the bulb. The stenosis of the left internal carotid artery (arrow) in the arteriogram in Figure 2C is more than 95 percent.

Case #2—(Figure 3) A 58-year-old hypertensive diabetic female presented with sudden onset of mild weakness and numbness of the right upper extremity. She had had successful left carotid endarterectomy three years before this admission. The non-invasive testing revealed a significant bruit at the bifurcation of the right carotid artery by CPA. F-OPG demonstrated a delay of the left ocular impulse. P-OPG pressures were 104 mmHg on the right and 100 mmHg on the left. Directional flow through the supraorbital artery was normal bilaterally. Carotid angiography confirmed the diagnosis of bilateral disease. After vein patch angioplasty of the recurrent proximal stenosis on the left, non-invasive testing indicated a significant right-sided bruit by CPA, marked delay of the right ocular pulse by F-OPG, P-OPG pressures over 110 mmHg bilaterally, and directional Doppler flow normal in direction bilaterally. Right carotid endarterectomy was performed without complication and



Figures 4—(Case #3) The phonangiogram (a) is negative for significant bruits but the F-OPG (b) demonstrates bilateral disease because both ocular impulses are delayed relative to the ear. After left carotid endarterectomy, routine F-OPG (c) demonstrated a marked delay of the left ocular impulse which suggested the acute thrombosis of the endarterectomy site as shown in the arteriogram (d). A 50 percent stenosis of the right internal carotid artery (small arrow) is also noted.

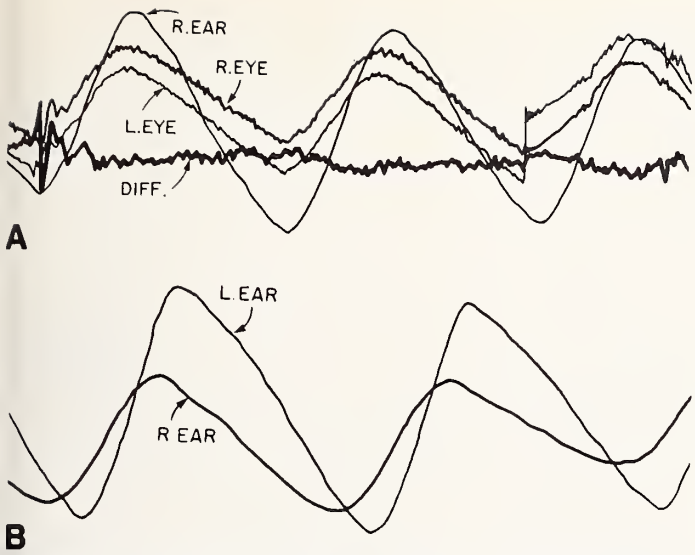
subsequent non-invasive tests were normal, indicating no hemodynamically significant lesions.

Comments: This case is presented to illustrate the value of serial noninvasive tests in following the patterns of atheromatous disease. The CPAs and the F-OPGs reproduced in Figures 3a and 3b demonstrate bilateral disease preoperatively, right-sided disease after left carotid repair, and normal flow bilaterally after right endarterectomy. Since F-OPG depends upon a comparison of right and left ocular blood flow, bilateral carotid disease can be difficult to detect. Note the P-OPG pressures of 104 mmHg and 100 mmHg and the mild delay of the left ocular pulse on the F-OPG tracing in Figure 3b and compare it to the marked right ocular pulse delay after left carotid correction in Figure 3f. This patient is also interesting because she had undergone a left carotid endarterectomy only three years previously.

Case #3—(Figure 4) A 59-year-old male with a history of diabetes, hypertension, and angina pectoris was examined because of an episode of left monocular blindness which lasted approximately 30 minutes. There was no evidence of bruits by CPA; F-OPG demonstrated bilateral delay of ocular impulses relative to the ear; P-OPG pressures were 105 mmHg on the right and 103 mmHg on the left; the directional Doppler detected normally directed flow in both supraorbital arteries. However, the flow on the left side diminished with compression of his superficial temporal artery. These results were suggestive of bilateral disease, sligtly more severe on the left side. Arteriography deomonstrated near-total occlusion of the left internal carotid; an ulcerating plaque of the left common carotid was also noted. The patient underwent left carotid endarterectomy and patch angioplasty. On the third postoperative day routine non-invasive testing showed no bruits by CPA; a left ocular impulse delay on F-OPG; P-OPG pressures were 106 mmHg on the right and 91 mmHg on the left; and directional Doppler showed reversal of left supraorbital flow with obliteration by compression of the external carotid branches. Because of these results, arteriograms were repeated and demonstrated an acute occlusion of the endartectomy site. The patient was reoperated and has done well postoperatively.

Comments: In this case non-invasive testing accurately identified an asymptomatic postoperative occlusion. As in the preceding case, the preoperative studies demonstrated bilateral disease: the P-OPG pressures of 105 mmHg and 103 mmHg and the subtle findings of bilateral ocular pulse delays when compared to the ear tracing (Figure 4a). Postoperatively, one would expect a tracing similar to the tracing in 3b demonstrating a marked delay on the non-operated side; however, the postoperative tracing (Figure 4b) unexpectedly showed a delay on the side of the surgery which suggested thrombosis of the endartectomy site. This patient's presenting symptom, transient left monocular blindness, probably was caused by emboli originating in the ulcerated, stenotic plaque on the left. Ulcerated plaques which are not hemodynamically significant will not be detected by non-invasive testing. It is our opinion that patients with symptoms suggesting embolic disease should have an arteriogram regardless of their non-invasive test results. It has been estimated that only 60 percent of ulcerated plaques are associated with stenotic lesions which can be identified in the non-invasive laboratory.[33]

Case #4—(Figure 5) A 64-year-old female presented five and a half years after a successful aortofemoral bypass with a right carotid bruit which was asymptomatic and found on routine examination. Non-invasive studies revealed a bruit above the bifurcation on the right side on CPA; F-OPG showed no delay in the ocular pulse but a delay in the right ear pulse suggesting right external carotid stenosis; directional Doppler detected normal flow through the



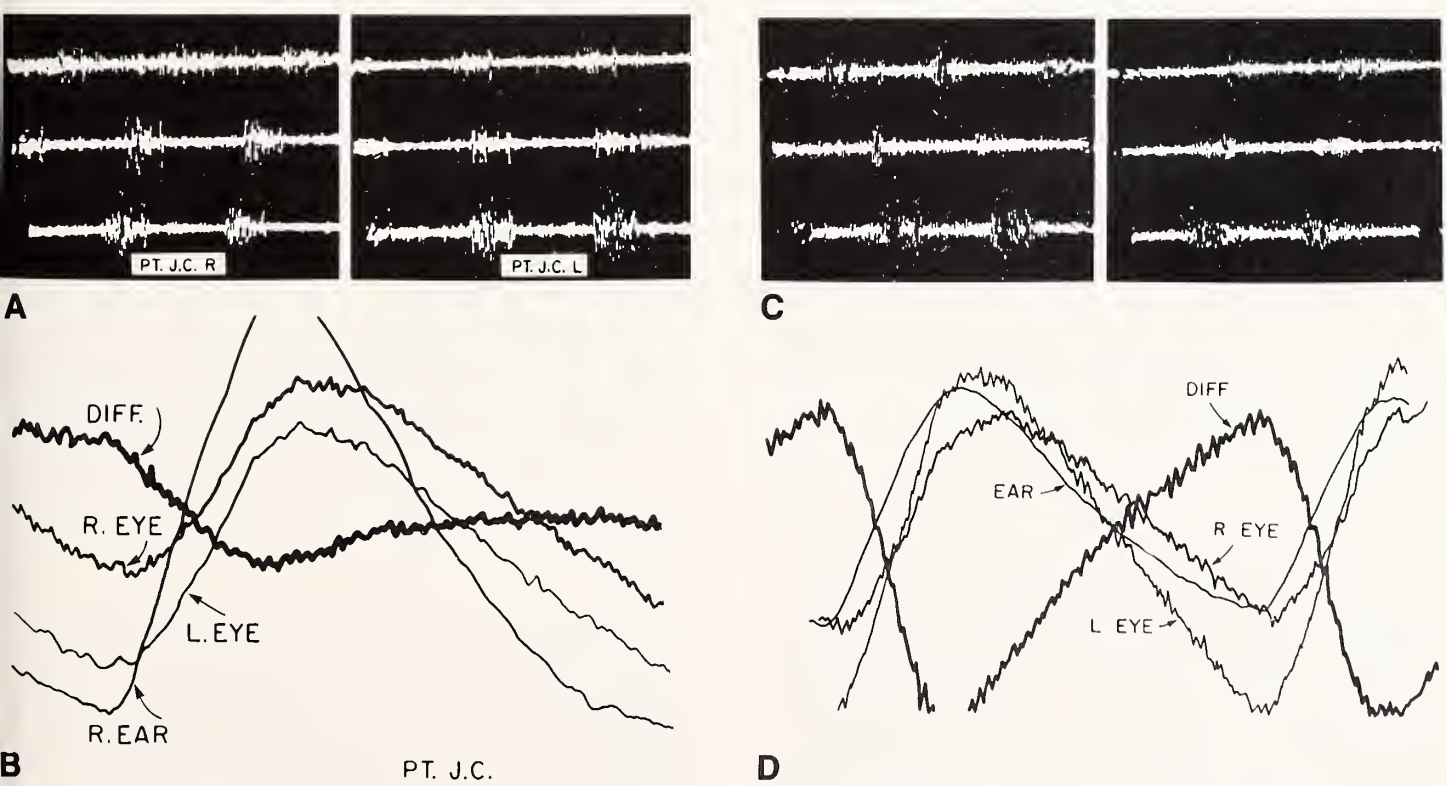
Figures 5—(Case #4) A F-OPG obtained in a patient with an asymptomatic right-sided carotid bruit demonstrates no ocular impulse delay indicating no internal carotid stenosis (a). The right ear impulse is also delayed when compared to the left ear (b), confirming the diagnosis of a right external carotid stenosis.

supraorbital artery; and retinal artery pressures by P-OPG were equal at 105 mmHg. Since the origin of the bruit was felt to be a stenosis of the external carotid artery rather than the internal carotid, angiography was not recommended. The patient remained asymptomatic until her death three years later from an acute myocardial infarction.

Comments: This report illustrates a long-standing problem for the physician, i.e., the proper selection of patients with asymptomatic bruits for arteriography. The natural history of the patient with an asymptomatic bruit suggests that these patients will have a higher incidence of stroke than the general population.[34,35,36] The CPA was positive for a bruit in the area of the carotid bifurction, but this test is unable to identify the origin of the bruit as being the internal, external, or common carotid artery (Figure 5). The F-OPG tracing (Figure 5), describing an external carotid lesion because of the right ear pulse delay, and normal directional Doppler and P-OPG studies were critical in the decision to withhold arteriography in this patient.

Case #5—(Figure 6) A 78-year-old male admitted with diabetes, hypertension, aortic stenosis, and first-degree heart block was examined for a recent transient ischemic attack presenting as weakness and numbness of the left lower extremity. CPA detected bruits over the bifurcation bilaterally; F-OPG demonstrated a delay of both ocular impulses relative to the ear; in addition, there was a slight delay of the right eye as compared to the left; P-OPG pressures were 95 mmHg on the right and greater than 110 mmHg on the left; flow was normal in direction in both supraorbital arteries. These results suggested bilateral carotid stenosis more severe on the right side. The patient refused arteriogram or surgery at that time. Two months later the patient was reexamined because of weakness and numbness of the left side of his body and dragging of his left foot. CPA showed no change in the left bifurcation bruit and a marked diminution of the right bruit; F-OPG now showed a marked delay of the right ocular impulse relative to the left; directional Doppler revealed a reversal of flow in the right supraorbital artery with obliteration of flow upon superficial temporal artery compression; P-OPG pressures were not done. Compared to the previous study, these results were interpreted as either a marked stenosis or complete occlusion of the right internal carotid artery; a complete occlusion was demonstrated by angiography. The patient required a permanent pacemaker for a worsening of his cardiac condition but has had no further cerebral episodes over the last two years.

Comments: The sequential use of non-invasive testing to monitor the progression of disease was quite valuable in this patient. The diminished right-sided bruit on the repeat CPA



Figures 6—(Case #5) The phonangiogram (a) depicts bilateral bruits and the F-OPG (b) demonstrates delay of both ocular impulses relative to the ear impulse. Two months later, the phonangiogram (c) shows the unchanged left bruit and a diminished right bruit, and the F-OPG (d) demonstrates a marked delay of the right ocular impulse, suggesting progression of disease on the right side to near-total occlusion.

Table II
Accuracy of Non-Invasive Testing As Compared to Angiography

Test	% Correct	% False-Positive	% False-Negative
1. CPA	61	26	13
2. Directional Doppler	71	12	17
3. P-OPG	79	4	17
4. F-OPG	80	14	6
5. Combined Tests	89	7	4

suggested an increased stenosis on that side (Figures 6a and 6c). The marked delay of the right ocular pulse in the followup F-OPG (Figure 6d) strongly suggested a near-total or recent total occlusion on that side. Followup directional Doppler studies became positive, with a reversal of flow in the supraorbital artery and cessation of flow with compression over the external carotid branches, signifying a near-total or total occlusion of the internal carotid. Presumably, the carotid artery was stenotic at the time of initial examination and progressed to complete occlusion.

ACCURACY OF NON-INVASIVE TESTS

The four non-invasive tests were compared to the arteriographic findings in 54 arteries (Table II). A critical stenosis was defined as a vessel diameter reduction of 60 percent or more.[32] On arteriography a positive non-invasive study was correct only when the arteriogram showed a 60 percent stenosis or more. A negative non-invasive study was correct when the lesion was less than 60 percent. A false-positive was a positive non-invasive test in an artery with less than 60 percent stenosis and a false-negative was a negative test result in an artery with a significant lesion of greater than 60 percent stenosis.

Carotid phonangiography was the least reliable test by this criterion. Significant bruits were produced by lesions reducing the arterial diameter by 30 percent or more and some stenosing lesion of 95 to 100 percent reduced flow so that no bruit was discovered. Recently, some investigators have attempted to use the amplitude of the bruit and its relationship to the cardiac cycle to estimate the degree of stenosis of the lesion.[4,10] This probably will increase the accuracy of the CPA in future examinations.

The directional Doppler had an overall accuracy of 71 percent. Since a reversal of flow through the ophthalmic artery only occurs with a severe impairment of flow through the internal carotid artery, the directional Doppler rarely detects lesions of less than 75 percent stenosis. Carotid compression maneuvers would increase the accuracy a few percentage points, but these are not performed at Newark Beth Israel Medical Center because of the potential risks of cerebral damage.[6,7,8,12,16]

P-OPG and F-OPG had similar accuracy. The high number of false-negatives for P-OPG reflected its difficulties detecting stenoses of 60 to 75 percent. These lesions may be well compensated by collaterals, resulting in minimal pressure drops.[8,12,13,14] The low percentage of false-positives, however, defines the test "specificity," *i.e.*, the test is highly reliable when positive. F-OPG, on the other hand, was the most "sensitive" test with a false-negative rate of only six percent; therefore, a normal test result was highly reliable. The false-negatives resulted from an insufficient pulse delay in patients with bilateral disease in two of three cases. Four of eight false-positives with the F-OPG resulted from overreading of a study demonstrating a minimal pulse delay due to stenosing lesions of 40 to 50 percent. A positive study in a normal artery can result from an anomalous ophthalmic circulation which may exist in three to four percent of patients,[10] but we were unable to demonstrate this in any of our patients.

The accuracy of the laboratory assessment was improved to 89 percent by combining the results of four tests for interpretation by an experienced evaluator. All of the false-positive studies and one false-negative study occurred in patients with a true positive study on the opposite side: four patients with significantly stenosed arteries on one side were thought to have bilateral disease and one patient with bilateral disease failed to have the lesser lesion, a 60 percent stenosis, identified correctly. The other false-negative study inexplicably failed to identify a 90 percent stenosis in a patient with unilateral disease. The patient underwent arteriography despite a completely negative non-invasive evaluation because of his clinical presentation. We feel that arteriography is necessary for patients with hemispheric transient ischemic attacks, regardless of the non-invasive laboratory results.

CONCLUSIONS

While none of the currently available non-invasive tests for cerebrovascular insufficiency is ideal, there are many practical applications for the primary physician, neurologist, or vascular surgeon. In our experience they: 1) are easily and safely performed, 2) improve the selection of patients for arteriography who have non-hemispheric neurological symptoms, 3) aid in the evaluation of patients in whom an

"Carotid phonangiography was the least reliable test. Significant bruits were produced by lesions reducing the arterial diameter by 30 percent or more and some stenosing lesions of 95 to 100 percent reduced flow so that no bruit was discovered."

"The accuracy of the laboratory assessment was improved to 89 percent by combining the results of four tests for interpretation by an experienced evaluator."

asymptomatic bruit has been detected, 4) monitor the progression of disease in patients through serial examinations, 5) evaluate endarterectomy patients postoperatively to identify early failures and late recurrences, 6) screen patients preoperatively to identify those at risk of a stroke, and 7) reassure the physician and patient with hemispheric symptoms that an angiogram will be rewarding.

When carefully interpreted by an experienced physician, the non-invasive tests are a reliable and useful adjunct in the management of patients with cerebrovascular disease.

"When carefully interpreted by an experienced physician, the non-invasive tests are a reliable and useful adjunct in the management of patients with cerebrovascular disease."

SUMMARY

Stroke prevention is a primary goal of the non-invasive vascular laboratory. Currently available tests identify occlusive carotid lesions by detecting an altered flow pattern or a reduction in blood pressure distal to a lesion. Because of implicit errors in indirect measurements, anomalous circulations, and varying collateral flow, no single test is 100 percent accurate. Moreover, no hemodynamic test can reliably detect lesions occupying less than 60 percent of the vessel lumen. A combination of tests (CPA, directional Doppler, P-OPG, and F-OPG), when interpreted by a physician familiar with the limitations of each, has an 89 percent accuracy as compared to arteriography. In our experience, the Non-Invasive Vascular Laboratory improves the selection of patients for arteriography, aids in evaluation of the asymptomatic bruit, monitors disease progression, screens high-risk patients, evaluates post-endarterectomy patients and confirms the need to repeat arteriography postoperatively.

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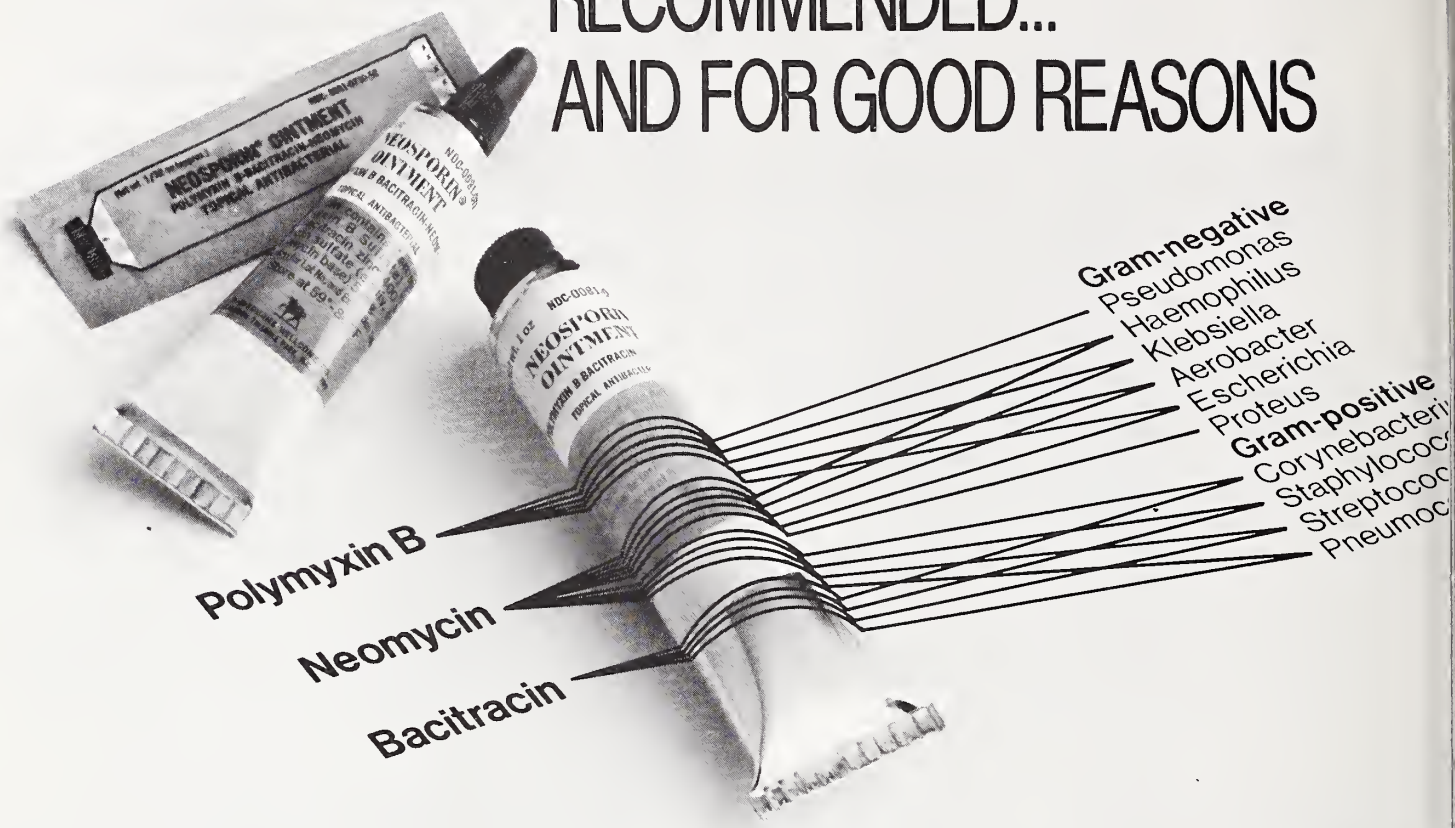

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Maternal Deaths in New Jersey—1978

JAMES P. THOMPSON, M.D., Paterson*

Twenty-seven maternal deaths occurred in New Jersey in 1978. Analysis of these deaths, including demographic and pathologic features, is presented. The wide range of etiologic factors associated with indirect maternal deaths makes it difficult to define an educational program to eradicate them. Anesthesia-related causes accounted for the largest percentage of deaths; difficulties with airway maintenance supplanted aspiration pneumonitis as a significant factor. The need for continued diligence on the part of the obstetrician is stressed.

The goal of maternal mortality review studies should be the prevention of maternal deaths. This is best accomplished by establishment of a system of data collection, intensive review of these data and the creation of effective educational programs that will influence future decision making. Continuing efforts to reduce maternal deaths in New Jersey are being directed along these lines.

A fall in the maternal death rate in New Jersey from 3.5 to 1.7 per 10,000 live births was reported during the years 1965 to 1974.[1] This decline was more apparent than real; the institution of a more intensive surveillance method has shown no significant decline during the last decade.[2] Previously, death certificates bearing a reference to pregnancy were forwarded from the Vital Statistics Program to the Maternal and Child Health Program of the New Jersey State Department of Health for review.

Presently, annual maternity service reports are scanned to locate deaths not detected by the death certificate mechanism and individual physicians, medical examiners, and hospital administrators are encouraged to report promptly any maternal deaths of which they are aware. The role and composition of the maternal mortality review committee have been described in a previous communication.[3] To date, the educational efforts of the committee have been somewhat hampered by the lack of awareness on the part of practicing obstetricians that committee members are available to discuss trends noted statewide in maternal deaths as well as aspects of individual deaths in which they have been involved.

This is best accomplished in the format of departmental meetings at the hospital in which the death occurred but seminars also have been presented in which members of a number of different hospital staffs have been present. While there is an understandable sense of reluctance on the part of the obstetrician having the misfortune to be associated with a maternal death to discuss publicly the aspects the committee deems preventable, patient and physician anonymity always have been preserved.

RESULTS

There were 93,356 live births in New Jersey in 1978; 27 maternal deaths were identified and presented to the committee for study. Table I presents the classification and rates as suggested by the American College of Obstetricians and Gynecologists.[4]

Five deaths occurred at home and the remainder occurred in twenty-one different hospitals throughout the State. Fifteen of the patients expired in the obstetrical suite; six occurred on the medical or surgical service and one in the emergency treatment area. Among the hospitalized patients, one expired undelivered; nine underwent spontaneous vaginal delivery and eleven delivered via cesarean section.

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Table 1
Classification and Mortality Rates

Live Births		93,356
Maternal Deaths		27
Non-maternal	3	
Indirect	10	
Direct	14	
Rate (indirect only)	11/100,000 live births	
Rate (direct only)	16/100,000 live births	
Rate (all causes)	30/100,000 live births	

Table 2
Characteristics by Race, Age and Prenatal Care

	Number	Percent
Race		
White	17	63
Black	10	37
Spanish Surname	0	0
Age		
Less than 20	3	11
20 – 34	20	74
35 – 39	4	15
Greater than 40	0	0
Prenatal Care		
None	7	27
Inadequate	2	7
Unknown	0	0
Adequate	17	63
Excluded (ectopic)	1	3

Table 3
Parity and Duration of Pregnancy

	Number	Percent
Parity		
0	11	40
1 – 3	12	44
4 – 6	2	8
More than 6	2	8
Gestational Age		
Less than 20 weeks	3	11
20 – 28	4	15
29 – 40	12	44
More than 40 weeks postpartum	8	30

Table 4
Pathologic Diagnoses for Non-Maternal, Indirect Obstetric Deaths

Non-maternal
- Suicide
- Adenocarcinoma of lung
- Leap from fire in dwelling

Indirect
- Subarachnoid hemorrhage
- Cerebrovascular anomaly
- Systemic lupus erythematosus
- Myocardial infarction
- Cholangitis
- Chronic hepatitis
- Rheumatic heart disease
- Peritonitis
- Chronic respiratory disease
- Unexplained

Tables 2 and 3 describe race, age, prenatal care and parity and gestational age. Nine of the twenty-six patients eligible for prenatal care received less than adequate care. Eleven patients were nulliparous.

Table 5
Pathologic Diagnosis for Direct Obstetric Deaths

Hemorrhage	1
Infection	1
Pregnancy-related hypertension	1
Miscellaneous	
Anesthesia	4
Cardiac disease	2
Renal disease	2
Pulmonary embolus	2
Unexplained	1

Table 6
Preventability of Maternal Deaths

Indirect Causes			10
Non-preventable		8	
Preventable		2	
1. Physician factor	1		
2. Patient factor	1		
Director Causes			14
Non-preventable		6	
Preventable		8	
1. Physician factor	7		
2. Patient factor	1		

PATHOLOGIC REVIEW

Autopsy reports were available on sixteen patients and a clinical diagnosis was assigned by the committee to the remainder. In an effort to facilitate the latter, verbal communication was established through a committee member with the treating obstetrician or consultants involved in the care of the patient. Through this combined approach, it was possible to assign a predominant cause of death in twenty-five of the patients studied. In the remaining patients—despite an autopsy in one—we were unable to explain the cause of death satisfactorily. Table IV lists associated non-obstetric causes of death and Table V lists deaths due to direct obstetric cause.

Table 4 is a summation of the non-preventable and preventable deaths. In the case of the latter, an assignment of contributory factors also was made.

COMMENT

A non-maternal death is an obstetric death resulting from accidental or incidental causes not related to the pregnancy or its management. There were three non-maternal deaths in the State in 1978; they have been included in the total but categorized separately. One patient died of metastatic adenocarcinoma of the lung; another died of multiple injuries sustained in a leap fleeing a fire; and a third patient with Friedrich's ataxia committed suicide. Personal communication with physicians involved in the care of the patient who committed suicide ascertained that pregnancy was not a precipitating factor and that numerous previous suicidal attempts had been made in the non-pregnant state.

The wide gamut of associated etiologic factors among the ten indirect maternal deaths makes it difficult to define a preventive approach. On the surface, a more effective family planning effort would appear to be the answer. Closer scrutiny reveals that among the deaths thought to be non-preventable, only the patient with systemic lupus erythematosus was known to have a pre-existing medical

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complication. Preventability was ascribed to the patient with rheumatic heart disease who failed to seek proper medical assistance in the postpartum period and to the consulting physicians who failed to diagnose intestinal obstruction prior to the occurrence of gangrenous bowel in the patient who died of peritonitis.

In past years, the majority of direct maternal deaths were included in the triad of hemorrhage, infection and toxemia.[3] The patient who died of hemorrhage was a nulligravid patient not known to be pregnant who was found dead at work. Fourteen hundred cubic centimeters of blood from a ruptured tubal pregnancy were found in the abdominal cavity at autopsy. This death was judged non-preventable. Deaths due to infection in the past were usually secondary to endomyometritis. One patient died of pneumonia after a cesarean section for a placenta previa. Respiratory failure and septic shock complicated the postoperative care. It was felt that this death possibly could have been prevented by a more aggressive antibiotic program at the first appearance of infection. The patient who died of eclampsia lapsed into a coma six hours after admission to the hospital and never recovered. In retrospect, the patient had a history of epigastric pain for a few days prior to admission and did not report this to the obstetrician. Thus, only twelve percent of the maternal deaths were attributable to the usual most common causes of such. Of these, two were deemed preventable.

A disturbing trend was noted among the four deaths related to anesthesia. Previously aspiration pneumonitis has been the prevalent related factor in deaths occurring with inhalation anesthesia. Almost fifty percent of parturients have a gastric fluid pH of less than 2.5[5] and pulmonary aspiration of the acidic gastric contents leads to an intense pulmonary reaction. This has led to the suggestion that any obstetric patient in labor routinely should be administered fifteen milliliters of antacid.[6] Two of the anesthesia deaths in this review were due to faulty positioning of the endotracheal tube. The first patient had general anesthesia and following extubation she became hypotensive and hypoxic. She was immediately reintubated, but during transport to the recovery room the tube apparently became dislodged and irreversible hypoxic changes occurred prior to recognition. A second patient had a spinal anesthetic for a repeat cesarean section and following closure of the uterine incision developed hypotension and bradycardia. Difficulty with proper placement of the endotracheal tube during the ensuing cardio-respiratory resuscitative efforts was followed by irreversible hypoxic changes. It is estimated that in this country at least 50,000 women undergo anesthesia and surgery at some time during their pregnancy for other than obstetric indications.[7] The scope of the anesthesia risk is even greater when the use of inhalation and regional agents for obstetric anesthesia is included. Pedersen and Finster recently have reviewed the physiologic changes unique to the parturient and presented useful guidelines to decrease the anesthetic risk in pregnant patients.[8]

A second disquieting trend was noted in the review of 1978 maternal deaths. A word of caution should be sounded concerning the increasing demand for home deliveries in the United States today. The review of these maternal deaths makes us particularly aware that there are potential lethal complications of a so-called physiologic process and that these complications frequently arise unexpectedly. Most obstetricians feel that a hospital-based delivery system provides the parturient with the greatest measure of safety. If out-of-hospital births are to be encouraged by consumer groups and women choose to deliver in out-of-hospital settings, we would ask that health officials make every attempt to supervise these settings.

In conclusion, we feel we constantly must stress that "the normality of obstetrics is its most dangerous feature. It demands that the physician be constantly on the alert."[9]

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STATE OF THE ART

The Pap Test in 1980

JEROME ABRAMS, M.D., North Plainfield*

A guide is presented for the identification of patients at high risk for uterine cancer and for the most effective methods of obtaining Papanicolaou smears. The principles of followup, management, and methods of eliciting patient cooperation are outlined.

Cytologic examination of the female genital tract has been responsible for the early diagnosis of premalignant and early malignant lesions of the cervix during the past twenty-five years.[1] In the United States, the incidence of invasive cancer of the cervix has decreased by 16 percent during the past five years alone.[2-4] (Table 1). During the past twenty-five years the death rate from breast cancer has not changed in the United States or in the rest of the English-speaking world despite improved treatment,[2,3,5] while the death rate from cervical cancer has continued to decrease (Tables 2 and 3). It is hoped that xeromammography eventually will become as effective a screening device for breast cancer as cytology has been for cervical cancer. The Pap test, which has resisted the tripling cost increase that has affected practically every product and service in our inflation-ridden economy, has grown in popularity from the occasional screening procedure in major teaching centers in 1955 to an annual test practically everywhere in North America in 1980.

CHALLENGES

Recently three problems have arisen to challenge the cytologic method of detecting premalignant and early malignant lesions of the female genital tract:

(1) The "public," represented by journalists[6] and public health administrators, has become superficially knowledgeable about the pathophysiology of the female genital tract and has challenged the cost-effectiveness[7] of Pap tests which are normal in most cases. The American Cancer Society[8] and the Canadian Task Force on Periodic Health Examinations,[9,10] responding to public pressures over mounting medical costs, no longer recommend annual Paps except for high-risk patients. The officials entrusted with the health care of the North American female genital tract and with the North American budget are expecting a continuation of our good results[2,3] (which are better than practically everywhere else in the world) at reduced cost.

(2) There has been an increasing incidence of abnormal cytology in younger women.[11-13] They frequently are unmarried girls who have never been pregnant and are not suitable candidates for the hitherto accepted circular cervical biopsy or conization. Earlier coitus, with its increased opportunity for consortial changes has long been associated with an increased incidence of cervical cancer.[4,11,12] Thus today's increased prevalence of earlier teenage coitus, as evidenced by earlier teenage pregnancies[14,15] and by an increased incidence of venereal disease[16,17] in all socioeconomic strata, has increased the membership in the high-risk category for cervical cancer. Although the American Cancer Society[8] has not excused the high-risk patient from annual cytologic screening, the responsibility falls upon the clinician to identify the high-risk patient and to justify the annual Pap test.

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Table 1
Incidence of New Cases of Cancer of the Female Genital Tract and Breast in the United States

	1974	1980 (Estimated)
Cervix	19,000	16,000
Corpus (Endometrial)	27,000	38,000
Ovary	17,000	17,000
Other Genital	4,700	4,500
Breast	89,000	108,000

Table 2
Death Rates from Breast and Uterine Cancer per 100,000 Population

	1967		1975		Percentage Decrease
	Breast	Uterus	Breast	Uterus	(uterine)
United States	22	10.8	22	7.7	30
Canada	23.5	10.2	23.6	7.6	25
Australia	19	8.3	20	7.2	13
England	24.6	9.7	27	8.8	9

Table 3
Cancer Deaths in the United States

	1974	1980 (Estimated)
Cervix	7,800	7,400
Corpus (Endometrial)	3,400	3,200
Ovary	10,700	11,200
Other Female Genital	900	1,000
Breast	32,000	35,500

(3) The increased incidence of endometrial cancer[4] has obligated clinicians to attempt to utilize cytology as a screening device for endometrial cancer[18,19] as well as for cervical cancer (Table 1).

EXAMINATION AND MANAGEMENT

The routine Pap test, which is considered primarily as a screening device for uterine cancer, consists of smears ideally taken from the posterior vaginal fornix, the exocervix, and the endocervical canal. Proper technique can be quickly acquired by the medical student, resident physician or nurse. Cytologic evaluation of the stained smears depends upon accurate labeling according to sites of origin and upon complete clinical information. As obvious as this seems, much time and money has been wasted and much unnecessary anxiety caused by erroneous interpretation due to inaccurate and incomplete information. A history of maternal treatment with diethylstilbestrol,[20] previous surgery, radiation and/or chemotherapy, current use of hormones, digitalis, anti-metabolites, and anti-inflammatory drugs,[21] the presence of an intrauterine device,[22,23] and the possibility of pregnancy are facts which are as important to the cytologist as they are to the clinician. Satisfactory communication between the cytologist and the clinician will promote prompt, accurate cytologic diagnoses.[12]

The course of action to be taken when the Pap test is reported as "abnormal" depends upon the clinician's understanding of exactly what the cytologist means by "abnormal." Originally Papanicoaou cytology was reported simply by classes as follows:[9]

Class I—normal cells present
Class II—atypical but benign cells present
Class III—possibly malignant cells present
Class IV—probably malignant cells present
Class V—malignant cells present

A newer nomenclature was introduced to correlate cytologic diagnoses with expected histologic diagnoses and to avoid the confusion that arises with Class II and Class III Paps.[1] Accordingly abnormal Paps are or should be reported today as degrees of cervical dysplasia or grades of cervical intraepithelial neoplasia (CIN) ranging from mild dysplasia or Grade 1 CIN to carcinoma *in-situ*. Although the newer nomenclature has not yet replaced the original Papanicolaou classification, it is no longer satisfactory or permissible to report abnormal cytology by the word "positive" or simply by a Roman numeral.[9,12] The clinician should expect the cytologist to amplify and explain reports designated as Class II or higher.

ACTION

If the Pap is reported as mild, focal dysplasia, the family physician or internist correctly may decide that gynecologic referral is not necessary because many mild dysplasias regress or disappear. Occasionally inflammatory reactions, especially cervical herpes[16] and condylomata,[22] have been mistaken for dysplasia. For this reason and because of the carcinogenic potential of herpes and condylomata, a repeat Pap should be taken three to six months later. Since there is a false negative rate of 10 to 20 percent[24] due to sampling errors by the clinician and/or unexplained desquamation of abnormal cells prior to taking the smears, one normal Pap particularly from a high-risk patient with a previous abnormal Pap, must be followed by another repeat Pap within one year.[25]

The practical difficulty lies in conveying enough information to enlist the cooperation of the patient without causing panic. If it is emphasized that the abnormal cells are not malignant but merely the result of an "irritation" which usually subsides, the patient may be content to wait three to six months for the repeat Pap, particularly if she can help

eradicate the "irritation." Since many of these high-risk patients exhibit a degree of vaginitis and/or cervicitis and also take oral contraceptives, a two-week course of anti-inflammatory vaginal cream[26] (plus flagyl® for trichomoniasis) and cessation of oral contraceptives[27] at least one month prior to the repeat Pap are advisable. Although there is controversy over the specific cytologic benefits of these innocuous measures, inflammation and oral contraceptives have been shown to cause confusing cytologic and histologic changes.[27] These two simple measures frequently facilitate more accurate cytologic interpretation three to six months later. Furthermore, they may serve to allay the patient's anxiety, contribute to her understanding of cervical neoplasia, and provide time to reevaluate her child-bearing plans.

Occasionally atrophic vaginitis and cervicitis confuse the clinician and cytologist. A two-week course of intravaginal estrogens in postmenopausal patients is advisable one month prior to the repeat Pap.[28] If the family physician or internist receives a report of moderate or severe dysplasia, or even mild but extensive dysplasia (abnormal cells scattered throughout many fields, from exocervical and endocervical sites) gynecologic referral is mandatory. The gynecologist always should receive a copy of the cytology report. As obvious as this seems, patients frequently appear precipitously in a gynecologist's office with only a verbal report of a "positive" Pap. Vaginal asepsis initiated by the referring physician together with cessation of oral contraceptives will provide the gynecologist with a cleaner and clearer view of the cervix for gross inspection as well as for colposcopic magnification.

Ten years ago the majority of gynecologists in North America, accustomed to accurate cytologic screening for premalignant and early malignant lesions of the cervix, felt little need for colposcopy. Detection of premalignant and early malignant lesions, which was much more effective than in Europe where colposcopy long had been popular, increased our belief that our method of screening was responsible for our superior results.[2,3] Most patients with abnormal cytology were married multiparas who usually entered the hospital for curettage and conization.[24] If the histologic diagnosis was carcinoma *in-situ*, the vast majority eventually agreed to hysterectomy. Today, however, with an increasing incidence of cervical dysplasia[12] in younger women (usually unmarried nulliparas in the high-risk category), colposcopically-directed punch biopsy[11,24,26,29,30,31] represents the more appropriate course of action. One or two or even three punch biopsies of the cervix, rather than conization, avoids the chances of postoperative stenosis and/or compromise of future fertility potential due to the excision of too much endocervical epithelium. Although most experienced gynecologists have performed conizations on patients who subsequently have had successful pregnancies, today's litigious climate favors colposcopy before contemplation of conization.

ENDOMETRIAL CANCER

The patient at highest risk for endometrial cancer is the obese postmenopausal diabetic, especially when nulliparous. However, any woman over forty with a history of abnormal bleeding should be considered a suspect for endometrial cancer until proved otherwise. Occasionally abnormal endometrial cells may be cytologically detected in a specimen from the posterior vaginal fornix,[18] but effective cancer screening[19] should include endometrial cytology obtained by

"The patient at highest risk for endometrial cancer is the obese postmenopausal diabetic, especially when nulliparous."

aspiration of the endometrial cavity with a narrow flexible plastic cannula. Very little gynecologic experience is required for endometrial aspiration. The information thus obtained with minimal time and effort may be invaluable in the detection of premalignant and early malignant disease of the endometrium.

Endometrial biopsy requires slightly more clinical experience and usually but not necessarily is restricted to the gynecologist.[32] Once endometrial aspiration has been accomplished, little additional discomfort is caused and little additional time is required for endometrial biopsy. Suction curettage may be an office procedure for selected perimenopausal and postmenopausal patients who have experienced recurrent bleeding several months after a "negative" curettage in the hospital, but it is not a routine annual procedure. Normal endometrial cytology and/or histology does not rule out endometrial cancer but it serves to avoid an emergency hospitalization and curettage.

COMMENTS

It has become possible to gain a greater understanding of the pathophysiology of cervical cancer through more widespread and more frequent use of and experience with colposcopy. The early detection and excision of premalignant lesions of the cervix, with an almost 100 percent cure, has convinced most North American physicians that there is no reason to abandon our method of cancer screening and prevention which is better than practically everywhere else in the world. Increased experience and expertise with colposcopy by the gynecologist and with endometrial cytology by the cytologist undoubtedly will improve our good results.

Fewer Paps probably should be taken from low-risk patients, but with more and more patients entering the high-risk category for cervical cancer and, with an already increased incidence of endometrial cancer, this is not the time to heed irresponsible charges that the Pap is not cost effective. Cancer is not cost effective and it is highly unlikely that the proponents of cost effectiveness will avoid the annual Pap test for themselves or for their consorts.

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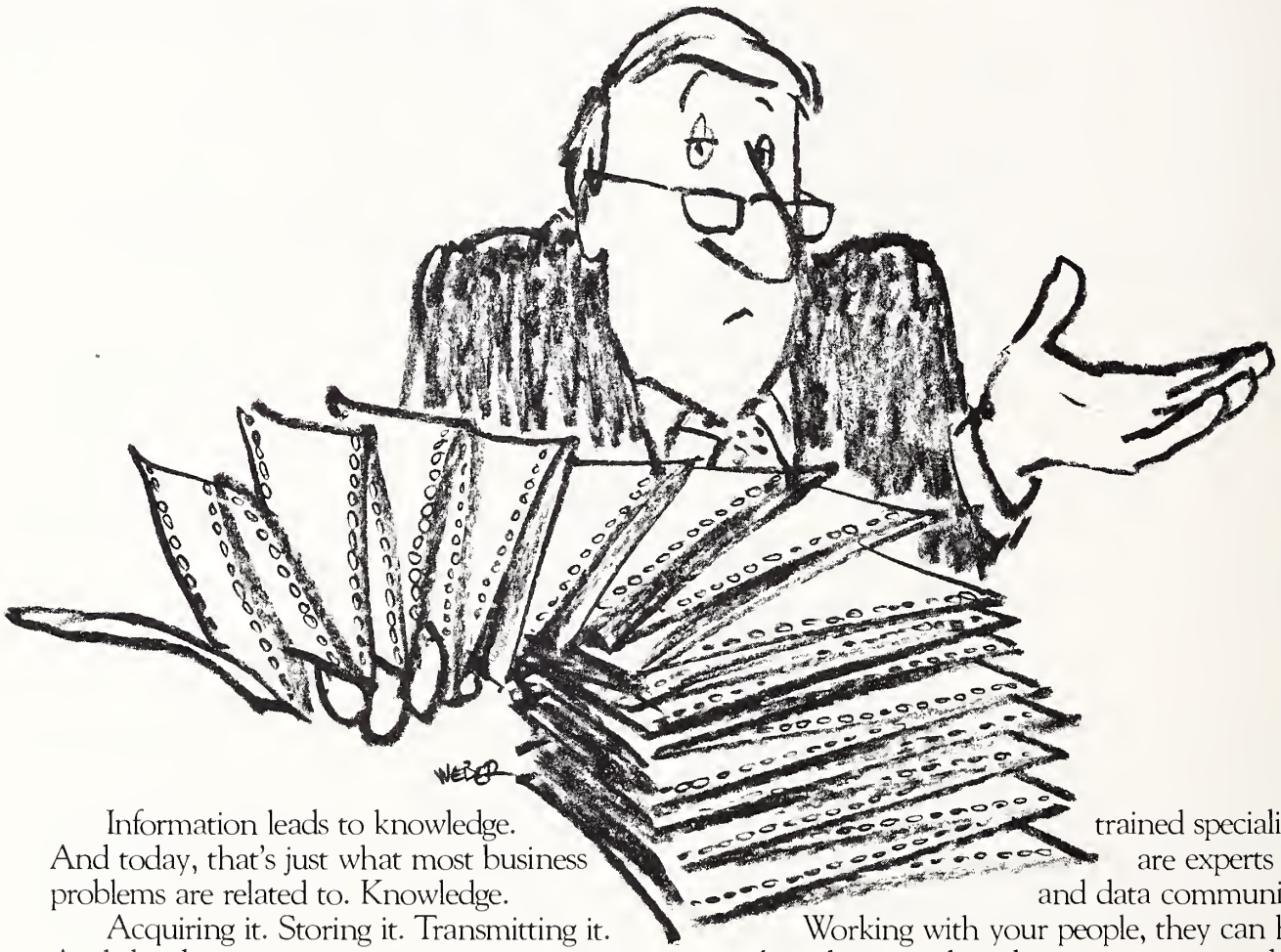

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CASE REPORTS

Association of Acute Intestinal Obstruction with Defects of the Broad Ligament

RICHARD J. KLINE, M.D., VICTORIANO MADRID, M.D., Morristown

Lacerations of the broad ligament are relatively common. They may occur following atraumatic obstetrical deliveries. Herniation of bowel through the defect causing intestinal obstruction is known to occur.

Internal hernia represents about one percent of the causes of acute intestinal obstruction. Hernia of the bowel through a defect in the broad ligament as a cause of acute intestinal obstruction was first described by Quain in 1861 when it was found at autopsy on a 36-year-old female. Sporadic case reports of this unusual condition occurred until Hunt, in 1934, presented a detailed report on the 13 cases published to that time.[7] By 1948, Baron was able to review 45 cases in addition to his own.[2] Approximately 65 cases have been reported.[3,5-9,11,16]

CASE REPORT

A 47-year-old female was admitted to Morristown Memorial Hospital with a 24-hour history of crampy, lower abdominal pains and vomiting. She had had a uterine suspension twenty-three years ago but the records of that procedure were not available. She had six pregnancies and no miscarriages. No other significant history was noted. Her temperature was 37.6 C, pulse: 90/minute, respirations: 20/minute, blood pressure: 110/80. The abdomen was distended and diffuse guarding, tenderness and rebound tenderness were noted. Bowel sounds were decreased in frequency. The rectal ampulla was empty.

X-rays of the abdomen revealed multiple dilated loops of small bowel with air fluid levels. A diagnosis of intestinal obstruction was made and a nasogastric tube was inserted. Intravenous fluids and antiobiotics were begun. On the day of admission a laparotomy was performed. Multiple dilated loops of small bowel were found. The uterus was retroflexed. The cause of the obstruction was a small segment of ileum which had herniated through a defect in the left broad ligament (Figure 1). A partial salpingectomy was performed which released the obstruction. Color returned to the portion of the intestine involved and resection was not necessary. The rest of the hospitalization was uncomplicated.

DISCUSSION

Hernia of bowel into the broad ligament is a rare condition. Standard texts of surgery[4] do not mention it, although other rare hernias such as lumbar and obturator hernia are described. The following causes of the defect have been suggested: (1) previous gynecologic surgery, (2) congenital anomalies, (3) defects resulting from previous inflammatory disease and (4) internal lacerations as a result of pregnancy or labor. Hunt was among the first to point out the relationship between the Baldy/Webster uterine suspension and the ligamental defect. At least three of his cases were directly related to failure to close the mesosalpinx during the performance of the suspension. Baron, in 1948, reported that 17 of the 45 cases that he reviewed followed the Baldy/Webster operation.[2] His was the last paper that

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Figure 1—Loops of small intestine incarcerated in right broad ligament. The dark loop of bowel returned to normal color after release of the obstruction. Resection was not necessary.

demonstrated such a large association between a particular surgical procedure and the broad ligament defect. Herman, in 1925, reported bilateral pouches in the broad ligament of an 18-year-old girl undergoing removal of pelvic tumor.[7] Rose, in 1962, reported a 16-year-old girl who presented with intestinal obstruction secondary to a broad ligament defect.[15] Neither of these patients had prior pregnancies, nor a history of previous inflammatory disease; they may represent congenital defects.

The original patient described by Quain[2] in 1861 and one reported by Finlaison[6] in 1946 are the only two patients in whom previous pelvic inflammatory disease seemed to be a causative factor. There is much more constant association of multiparity and broad ligament defects. Approximately 80 percent of Baron's patients were multiparous.[2] One case has been reported in which the herniation occurred during the eighth month of pregnancy in a multiparous woman. Allen and Masters, in 1955, were the first to note broad ligament lacerations of obstetrical origin.[1] They presented 28 cases and related the occurrence of lacerations to precipitate and traumatic deliveries and occasionally criminal abortions. Lawry, in 1967, presented 23 additional cases of broad ligament lacerations, in multiparous women, 19 of whom had no history of difficult delivery.[10] The ease with which he collected the 23 cases suggested the broad ligament defects may occur during pregnancy more commonly than suspected. The patient described here had a history of previous uterine suspension, although no evidence of previous surgery was found at laparotomy. It is our feeling that multiparity was a source of the ligamental defect.

The diagnosis never has been made preoperatively. Symptoms are usually those of a small bowel obstruction since the ileum is most commonly incarcerated, however, colon and ovary also have been the source of symptoms.[14] Early laparotomy is important to prevent infarction of the bowel. Surgical repair may include reconstruction of the ligament or a salpingectomy. Since there is a relatively high occurrence of bilateral defects, the opposite broad ligament should be thoroughly inspected.

CONCLUSION

An acute intestinal obstruction through a fenestra of the broad ligament of a multiparous woman is presented. The etiology is difficult to determine, but multiparity and previous uterine suspension frequently are associated. The seriousness of the condition requires immediate laparotomy.

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Aeromonas Hydrophila: A Significant Human Pathogen *

YOGESH K. GUPTA, M.B., NIRMAL K. FERNANDO, M.B. and
DAVID V. ALCID, M.D., Piscataway

Five cases of *Aeromonas hydrophila* infections are presented. They include two patients with bacteremia secondary to biliary tract disease, one patient with aspiration pneumonia and two cases of wound infection with water and soil contamination. Clinical presentation, diagnosis and therapy are discussed.

Aeromonas hydrophila is a member of the family Vibronacease, genus Aeromonas. It is a facultative aerobe, motile, oxidase-positive, gram-negative rod normally found in water, soil, and sewage. Aeromonas is pathogenic to marine and fresh water animals. In man, it produces septicemia, especially in patients with impaired host defenses, and wound infection, cellulitis, gastroenteritis, cholecystitis and peritonitis.[2,3,5,6] Our experience with infections due to this organism suggest that it should be suspected as the causative organism in certain clinical situations as illustrated by the following five cases.

CASE REPORTS

Case 1—A 76-year-old female was admitted to the hospital with an eight-week history of explosive watery diarrhea fifteen to twenty times a day, without blood or mucus. She denied associated anorexia, nausea, vomiting, abdominal pain, fever or chills. Treatment with diphenoxylate and paregoric was not effective. Twenty-eight years ago, she had a mastectomy for carcinoma of the left breast. Two years ago a fractured left hip was repaired with an intramedullary nail. The admission physical examination revealed a temperature of 37° C, pulse 84 per minute with a regular rhythm, and blood pressure 130/70 mm Hg. She was dehydrated, pale and icteric. Pertinent findings were confined to her abdomen which was moderately distended with diffuse tenderness without rebound. The bowel sounds were hyperactive.

Laboratory Data: Hemoglobin 13.9 gm; hematocrit 41.5%; white blood cell count 20,900 per mm^3 with 85% polymorphonuclear leukocytes and 10% band forms, 5% lymphocytes. Total bilirubin was 3.7 mg/dl (direct bilirubin 1.7 mg/dl) Alkaline phosphatase 339 mU/mL (30-120 mU/mL); LDH 230 m U/mL (100-250 m U/ml); SGPT 75 m U/mL (6-37 m U/mL); SGOT 88 m U/mL (5-45 m U/mL); GGTP 165 mU/mL (3-35 m U/mL). Stool smear was negative for leukocytes. Serum electrolytes: Na 120 m Eq/L;K-1.5m Eq/L HCO_3-27 m Eq/L (Cl-81m Eg/L). On the second hospital day, her temperature rose to 39° C, so three blood cultures were obtained. Tobramycin (80 mg I.V. every eight hours) and ampicillin (1 g IV every eight hours) were begun for a presumptive diagnosis of ascending cholangitis. All blood cultures grew *Aeromonas hydrophila* sensitive to gentamicin, tobramycin and resistant to carbenicillin and ampicillin. Therapy was continued with tobramycin alone. The stool cultures were negative for enteropathogens including Aeromonas. Grey scale sonography of the abdomen, upper GI, small bowel studies and barium enema were negative. The fever and diarrhea subsided on the fifth hospital day and the liver function studies improved. An intravenous cholangiogram revealed faint

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". . . Aeromonas sepsis in the compromised host has a reported mortality of 50 percent."

visualization of the gallbladder and a common bile duct measuring 15 mm with multiple filling defects. Tobramycin was discontinued after 14 days. At this time, the laboratory studies revealed total bilirubin 0.8 mg/dl., alk. phosphatase 705 mU/mL, LDH-150 m U/mL and SGOT-64 mU/ml. An ERCP was performed on the thirtieth hospital day and multiple small stones were removed. An elective cholecystectomy was performed two months later.

Comments—This patient's clinical presentation was a combination of "cholera"-like diarrhea and ascending cholangitis. The etiology of the diarrhea is unclear since enteropathogens were not isolated from stools. However, it is remarkable that chronic diarrhea as well as the "ascending cholangitis syndrome" subsided with the institution of appropriate antimicrobial therapy. In one report of two cases of Aeromonas septicemia from hepatobiliary disease diarrhea was not a feature.[6] Aeromonas species have been implicated in choleraic diarrhea[7] and bloody diarrhea[8]. It is known that this organism produces a heat labile enterotoxin[9]; it may have been responsible for her diarrhea.

Case 2—A 77-year-old previously healthy male was hospitalized because of right upper quadrant and epigastric pain associated with nausea and vomiting of two-days duration. The patient had no history of similar symptoms previously and no fat intolerance.

Physical Examination: Temperature 37.4° C, pulse 80 per minute; blood pressure 150/80 mm Hg. Pertinent physical findings were limited to the abdomen. There was right upper quadrant tenderness with rebound and active bowel sounds. Laboratory data: Hemoglobin 14.1g; Hematocrit 39.1%; WBC 10,400 per mm^3 with 84 polys, 4 bands, 9 lymphocytes; alkaline phosphatase 10.7 Units (4-13); total bilirubin 1.3 mg/dl. Sonogram of the gallbladder revealed multiple calculi.

Hospital Course: The patient continued to have colicky abdominal pain. On the fourth hospital day, he became febrile (39°C). After blood cultures were obtained, he was started on cephalothin in dose of eight grams per day. A cholecystectomy was performed the following day; the gallbladder was found actively inflamed. The following day, blood cultures and gallbladder culture grew a gram-negative rod which was eventually identified as *Aeromonas hydrophila.* Therapy was changed to gentamicin 80 mg intravenously every eight hours. The patient recovered and was discharged on the tenth post-operative day.

Comment—In this case and the previous one, the source of the sepsis was the biliary tract. To our knowledge, three other cases of Aeromonas sepsis associated with hepatobiliary disease have been reported; with appropriate therapy all have survived.[6] Aeromonas bacteremia in the normal host carries a good prognosis, but Aeromonas sepsis in the compromised host has a reported mortality of 50 percent.[12]

Case 3—A 13-year-old male was admitted to the hospital with a history of having drowned in a river. The patient was submerged for five to eight minutes and on retrieval by the rescue squad, cardio-pulmonary resuscitation was administered.

On admission, the patient was comatose, cyanotic and hypothermic with a rectal temperature of 32.5°C. His blood pressure was 130/110 mm Hg. and pulse 92 per minute. The patient had been intubated in the emergency room of the local hospital. Bilateral coarse rales were heard. Assisted mechanical ventilation was administered. The chest x-ray revealed a left lower lobe infiltrate, but the following day, the chest x-ray revealed pulmonary edema. Diuretics and digoxin were administered. Forty-eight hours after admission, he became febrile with a temperature of 39.5° C. Leukocyte count was 18.90 with 74% polymonophonuclear leukocytes, 14% nonsegmented forms and 12% lymphocytes. Gram stain of the endotracheal aspirate revealed many polymorphonuclear leukocytes and gram-negative bacilli. He was treated with a combination of clindamycin, 600 mg every eight hours, and gentamicin, 80 mg every eight hours. The culture of the aspirate revealed heavy growth of *Aeromonas hydrophila* and Klebsiella species. The pulmonary and neurological status did not improve and the patient expired four days after admission. Permission for autopsy was refused.

Comment—In Washington's series there were two cases of *Aeromonas hydrophila* in mixed culture isolated from the sputum;[2] but other bacteria were considered to be the significant pathogens. Von Gravenitz and Mensch also described four cases where the organism appeared in mixed culture.[1] But, unlike the other cases, he was admitted after being submerged in fresh water. Subsequently, he developed a left lower-lobe pneumonia. In this setting we believe that *Aeromonas* was partly or wholly the responsible pathogen. We realize that the patient was intubated and artificially ventilated and that organisms from an endotracheal aspirate culture do not necessarily signify a pulmonary infection. However, McCracken, on studying numerous hospital environmental samples over a three-year period, did not isolate Aeromonas even once though many other gram negative species were isolated.[3]

Case 4—A 46-year-old female was seen in the hospital with a history of having stepped on hot coals one week previously. There was a second-degree burn of approximately three cm. in diameter with surrounding cellulitis on the plantar aspect of the left foot. The culture of the exudate aspirated from a bullous lesion grew *Aeromonas species* and *Staphylococcus aureus.*

Comment—Rosenthal described seven patients with Aeromonas wound infection. Two patients are described in detail. One had a wound secondary to an alligator bite and another a wound from a water skiing accident. Another patient had second-degree burns but no details were given. Aeromonas frequently can be isolated from the soil and our patient's burn was on the plantar aspect of her foot. Therefore, it would be assumed that soil contamination of the burn took place.

Case 5—A 32-year-old female presented to the hospital emergency room with a lacerated wound over the left medial malleolus after falling out of a canoe. Initially, she was seen at a local hospital when the wound was sutured and a Penrose drain was placed. One week later, she presented with a purulent discharge from the wound. The culture of this

"Aeromonas septicemia is a recognized clinical entity in the compromised host with a gastrointestinal tract as the probable source."

discharge revealed a heavy growth of *Aeromonas hydrophila.*

Comment—The literature contains many examples of isolation of *Aeromonas hydrophila* from wounds secondary to water-related trauma.[2,3,10,11] These include trauma associated with water-sports lacerations sustained from dead trees and branches in lakes.

SUMMARY

The foregoing case reports illustrate the clinical conditions under which *Aeromonas hydrophila* should be suspected as the causative organism. Water-associated trauma and soil contamination deserve special consideration. Aeromonas septicemia is a recognized clinical entity in the compromised host with a gastrointestinal tract as the probable source; it carries a high mortality[12]. In the normal host, when th source of bacteremia is unclear, the biliary tract should b investigated.

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SPECIAL PRESENTATION

The AMA in the Forefront

WILLIAM S. HOTCHKISS, M.D., Norfolk, Va.*

Dr. Alessi, Dr. Baker, Dr. Todd, Mr. Speaker and members of the House of Delegates of the Medical Society of New Jersey. I appreciate the opportunity to address your House of Delegates, and I want particularly to express the appreciation of my wife and myself for the wonderful hospitality afforded us over the last three or four days.

For a long time I have been impressed with the very fine delegation that you send to the American Medical Association. It is a very strong, active and hard-working delegation. Early yesterday morning, I conducted what is known as the "Official Family Briefing," in which your leaders and I discussed the many major issues that concern American medicine at this time. I purposely avoided speaking of the problem of membership—not because it isn't important, but because it is probably the most important. I think it is so important that it should be discussed with your entire House.

AMA MEMBERSHIP AND BUDGET

All of you know, I think, that membership in the AMA is one of our most serious problems. There are 437,000 physicians in the United States; 373,000 of these are in active practice, and 342,00 are engaged in patient care. There are 224,000 AMA members in all, and of these only about 152,000 are full dues-paying members. However, there are a couple of figures of which we're really proud: over 20,000 medical students and over 20,000 residents are members. This constitutes over one-third of all medical students and residents—a proportion about equal to that of the practicing physicians who are members. All of this interface with these younger people has happened since 1972/1973, when their membership categories were created in the AMA. They are carried at a lower dues structure, as they properly should be, and maybe they are a loss leader. But they are an excellent investment in the future of American medicine, because most of them, when they go into practice, will continue to be members of the AMA.

The most important fact I want to address is that only about one-third of the physicians in the United States are carrying the financial load of AMA activity. There are 120,000 doctors out there who don't belong to any part of organized medicine—county, state, or AMA. Another 60,000 belong to a state society but don't belong to the AMA.

We have a $62 million budget in the AMA, and even a ten percent inflation rate would increase it $6 million a year. Increasing our income $6 million a year would require 24,000 additional full dues-paying members a year. We should get them—but we won't, not the way our federation currently is organized. I am completely dedicated to the proposition that every physician ought to belong to the county society, the state society, the AMA, and a PAC. Belonging would cost you six or seven hundred dollars a year—almost all of which is tax deductible, all but the PAC portion. Not belonging would cost you infinitely more: your professional freedom.

AMERICAN MEDICINE

American medicine is clearly the best in the world today, but it is worthwhile to reflect on the fact that this was not always so. Sixty or seventy years ago it was customary for the leaders of American medicine, after they completed what training they could get in this country, to go to Scotland, England or Central Europe. Europe and medicine came under the stiffening control of increased regulation, and progress slowed. Meanwhile, in this country, the pace of discovery and the quality of care improved steadily. Today, we see doctors coming to this country from all over the world to learn our techniques and our methods of care. Most of them are so impressed with the superiority of American medicine that they choose to stay here all their lives. It is our obligation to further this heritage of discovery and quality and to protect it in every way we can. We must also be concerned with the kinds of regulation that may, as happened in Europe, threaten the delivery of health care. We must be sure that we monitor and comment on such programs as Medicare, Medicaid, HMOs, PSROs, and HSAs so that they do not have an adverse impact on the delivery of medical care. This can be done most effectively by physician participation in all levels of planning and implementation. The American Medical Association is in the forefront of review, criticism, and participation in the ongoing evaluation of such government programs.

WHY NOT TO JOIN

In view of this continuing need to monitor, respond to and provide leadership to the many facets of health care delivery, what kinds of reasons can doctors give for not belonging to the AMA—that organization that will serve them best? Many reasons are given, but some of them are superficial

*Dr. Hotchkiss is a member of the Board of Trustees of the American Medical Association. This presentation was made before the House of Delegates of the Medical Society of New Jersey, May 12, 1980.

excuses and not the actual reason. Many will say, "I don't like the policy on HSA" or "I don't like the policy on PSRO," and "therefore I am not willing to belong." It happens that I myself didn't like either of these policies when they were put in, and I debated in the reference committee on the negative side of each. But the House did what we had to do in order to comply with the law; the House was right, and I accept that. We had an exhaustive debate before we adopted those policies, but we had to comply with the law. No one will ever agree with every position that is written in an organization composed of a group as diverse as American physicians. If you make agreement a condition of your membership in any organization, you will never join anything worthwhile. So much for excuses.

There are really two basic reasons why doctors don't join the AMA. First, some are just too tight to pay the dues. This was true even when the dues were $25, although it is even truer now that they're $250. Most of us have served as treasurer of some hospital staff or medical society, and we know that penurious doctors simply don't like to pay their dues and will drag their feet until they are coerced. Second, many physicians don't know what the AMA does for them.

AMA ACTIVITIES

There are so many important activities that we just take for granted. But to cite just a few:

• The AMA serves as a repository for—and has a Judicial Council for—medical ethical standards. Would any physician want any other than a national organization of physicians to carry out this task? Would he or she go for the HEW or the FTC doing it? Surely not.

• The AMA provides organized medical input into important medical education bodies: i.e., the boards, the medical schools, and the residencies. It provides the same type of input into the Joint Commission on Accreditation of Hospitals. This is vital to our relations to hospitals. If we didn't have that input, the hospitals would exercise much greater control over us.

• The AMA has a physician placement service, which is available to all AMA members at no direct cost to doctors.

• The AMA studies and publishes authoritative, unbiased reports on drug therapy.

• The medical liability activities of the AMA are not widely known, but many of the malpractice legislative reforms passed in the 50 states in recent years originated in the General Counsel's Office of the AMA. And that accounted for many thousands of dollars and many thousands of hours.

• The AMA lobbied for many years to get the Keogh Plan. For just this simple activity that you probably never thought about, you can thank the AMA, because it will save you more in taxes than you ever will pay in a lifetime of being in the AMA. If a physician knows of these and of other activities of the AMA, there is just no way he can make a case for not being an AMA member. The AMA helps all of us in so many ways. Why then, I ask you, is it so unreasonable to ask that each of us share in its financing? If everybody did his or her share, it is calculated that the dues rate at any given time probably could be reduced by $55 to $60 a year.

• Let us consider national leadership for medicine in America. The AMA is surely the only organization remotely capable of providing it. When Congress or the Administration wants testimony on the position of American med cine, it is the AMA they ask to comment. In the last Congres there were 10,000 bills introduced, and 2,500 of them (one fourth) had medical connotations. Who else is going to stud and analyze all of these bills except the AMA? Most stat and specialty societies can't possibly handle that plus constant stream of either oral or written testimony. And you don't recognize that the AMA is the leader in America medicine, rest assured that our enemies do, the people wh are trying to discredit us.

THE NONMEMBERS

I want to consider those people, however, who are not hei today; the ones who are not active even in the local and stat societies. Those doctors don't even receive the *AM News* t get a balanced view. They are completely at the mercy of th commercial media—which, as you know, often have a liber orientation. And what is worse, many of these doctors n only swallow that propaganda but help disseminate it. B when you criticize the AMA, you are criticizing America medicine.

Just consider how much stronger a position you would b in if all physicians were members—and how much better th AMA could represent you in Washington and elsewhere, an how much more clout you could have. If the AMA could b pried loose from its position of leadership of America medicine, there are quite a few candidates standing in th wings waiting for the role. I would hate to depend on any on governmental agency or narrowly defined organization t totally defend my professional freedom. I can say to you tha no organization other than our national organization ap propriately can fight the fight that needs to be fought t protect the professional freedom of the practicing physician Working with local and specialty societies, we cannot hel but put forth the strongest possible position. With this i mind it seems to me that any physician who wants to oppos the proposition of combined membership is obligated to as himself or herself a few questions. (1) Is the AMA a force fc good in American medicine? Obviously the answer has to b yes, I defy anyone to make a case for the negative. (2) Doe he or she feel that there should be an AMA? Of course. (3 Then why not pay a fair share of money—to say nothing c time that so many others give so freely for the support of th organization? (4) If I had come here as a delegate instructe to vote in the negative, is it because I failed to do my part t point out the advantages of AMA membership?

UNIFICATION

Now you hear all kinds of allegations that if you g unified, you'll lose a lot of members in the medical stat society. Let me tell you that this hasn't happened in the othe states that are unified, such as Illionis, Arizona and Oklahc ma. We have heard the oratory that this issue brings forth o freedom and compulsuion and the analogies that are draw to the closed shop. But ladies and gentlemen, I am with yo on these points. If unified membership were compulsion c an abridgement of freedom or a closed shop, then I woul have to be against it. But to me, it is none of these things. N one really is required to join anything. A doctor can practic medicine, he can have all the privileges without belonging t any part of organized medicine. But if we are getting beat a we now are organized (and we surely are), and if we ar losing ground as we now are organized (and we surely are and if free enterprise medicine is standing on the brink c destruction as we now are organized (and it surely is), the

y the grace of God we have not only a right but an bligation to organize better. We have a right to say to the hysicians of America that organized medicine is a unit from ounty to state to AMA. We want you to be a part of it, we eed you and you need us. So you have an option—you can ay out or you can come in. But you can no longer come ne-third of the way in or two-thirds of the way in and use e endorsement this position gives you as a platform to riticize the other part of the organization. That's not ompulsion, or abridgement of freedom, or a closed shop. It simply a strong and proper organization.

One could cite many old quotations to this point: "United e stand, divided we fall." "We must hang together or we ill surely hang separately." "A house dividied against itself cannot stand." But there's one that I like best. It comes from a more modern, home-spun philosopher, Elbert Hubbard. It is titled "Loyalty." It has only nine lines: "If you work for a man, in heaven's name work for him. Speak well of him and stand by the institution he represents. Remember, an ounce of loyalty is worth a pound of cleverness. If you must growl, condemn, and eternally find fault, why—resign your position, and when you are on the outside, damn to your heart's content. But as long as you are part of the institution, do not condemn it. If you do, the first high wind that comes along will blow you away, and you will probably never know why."

And I'll leave you with this thought. Where will you stand when "The high winds are blowing on American medicine?"

RADIOLOGY NOTE

The Hypertrophic Costochondral Junction Masquerading as a Pulmonary Nodule*

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Computed tomography (CT) of the chest, including evaluation of the pulmonary parenchyma and mediastinum, now has been demonstrated to be a valuable technique in the diagnosis of pulmonary nodules[1,3]. While conventional lung tomography may demonstrate 10 to 15 percent more nodules than routine chest radiography[4], CT of the chest can detect a higher percentage of nodules than either technique.[5]

It has been documented that not all pulmonary nodules seen by chest CT are metastatic lesions. Granulomas, subpleural lymph nodes, pleural thickening and fibrosis and prominent pulmonary vessels may be seen as discrete nodular densities by CT and may, therefore, interfere with the correct diagnosis and treatment. Recently, Kolbenstvedt *et al.* reported the appearance of an anomalous azygos vein and lobe on chest CT and noted that this variant may be mistaken for a pulmonary nodule or pleural based mass.[6]

CLINICAL MATERIAL

Three examples of prominent costochondral junction hypertrophic spurring, which initially could have been mistaken for a neoplastic pulmonary mass on chest CT, recently have been encountered. All cases were being evaluated because of suspected primary bronchogenic carcinoma on routine chest radiography. Computed tomography was utilized to demonstrate the possibility of additiona parenchymal lesions, as well as possible spread to th mediastinum.

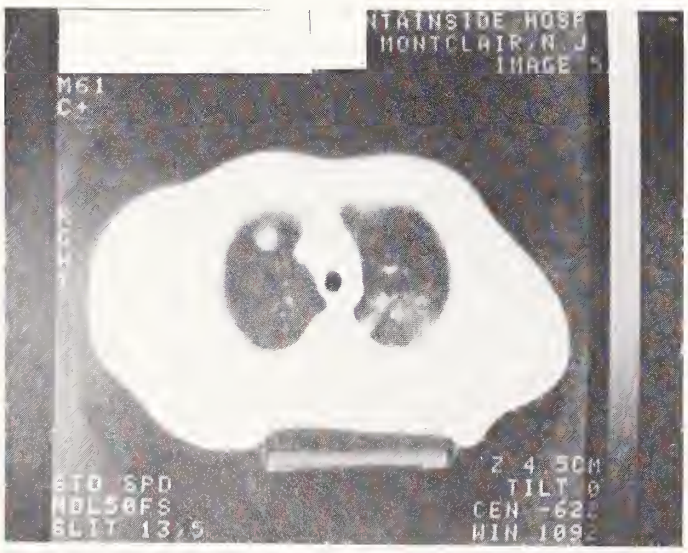

Figure (1a)—Reveals a well-marginated mass in the right apex. The attenuation coefficient measures −630 Hounsefield units.

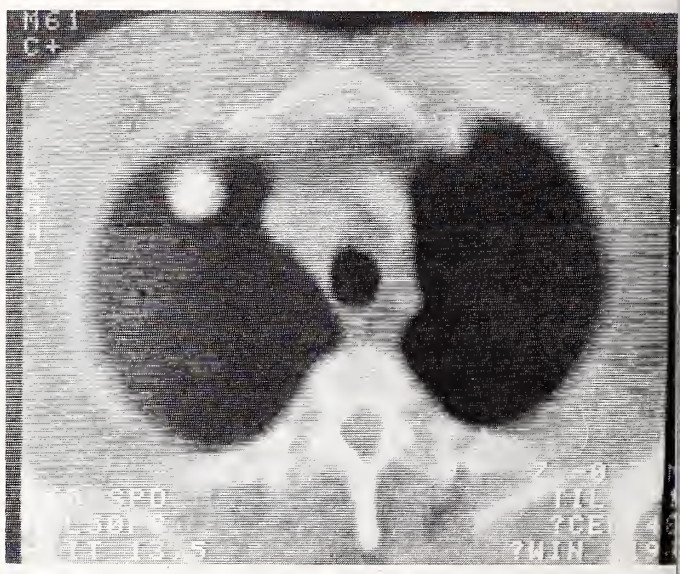

Figure (1b)—Illustrates the definite central osseous ar cartilaginous appearance of the mass with an attenuation coef cient of +232 Hounsefield units.

Productive change at the first costochondral junctio commonly is observed by routine chest radiography. Usua ly, this bony and cartilaginous spurring projects inferior and posteriorly allowing for a portion of lung to encircle th spur in the transverse plane.

The initial series of CT images revealed a suspiciou nodule (Figure la) with an attenuation of minus 63 Hounsefield units. This low attenuation coefficient wa obviously due to the partial volume effect. Repeat C imaging at a slightly different level again showed the discre mass with an attenuation coefficient of minus 232, reflectin again the partial volume effect. Subsequently, overlappin CT sections with appropriate manipulation of the windo levels identified the true bony and cartilaginous nature of th density with the inner architecture being clearly osseous i appearance represented by an attenuation coefficient of plu 330 Hounsefield units (Figure 1b). Upon review of the P and lateral chest radiograph and conventional chest tom

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Figure (2a, b)—Posterior-anterior chest radiograph reveals productive spurring at the right first costochondral junction. Lateral film (arrowheads) demonstrates posterior and inferior projection of the spur.

Figure (2c)—Conventional tomography demonstrates to better advantage the prominent productive change (asterisk).

graphy (Figures 2a, b, and c), the prominent costochondral junction was readily apparent.

Two additional cases presented in nearly an identical fashion. It is anticipated that this finding will be encountered quite frequently.

CONCLUSION

With the increasing use of CT to evaluate pulmonary pathology, it is imperative that this anatomic variant be recognized so that inappropriate medical and/or surgical treatment will not be instituted. Careful correlation with conventional chest radiography and the use of overlapping CT sections should enable the correct diagnosis to be made in all cases.

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The Dilemma of Sinusal Bigeminy

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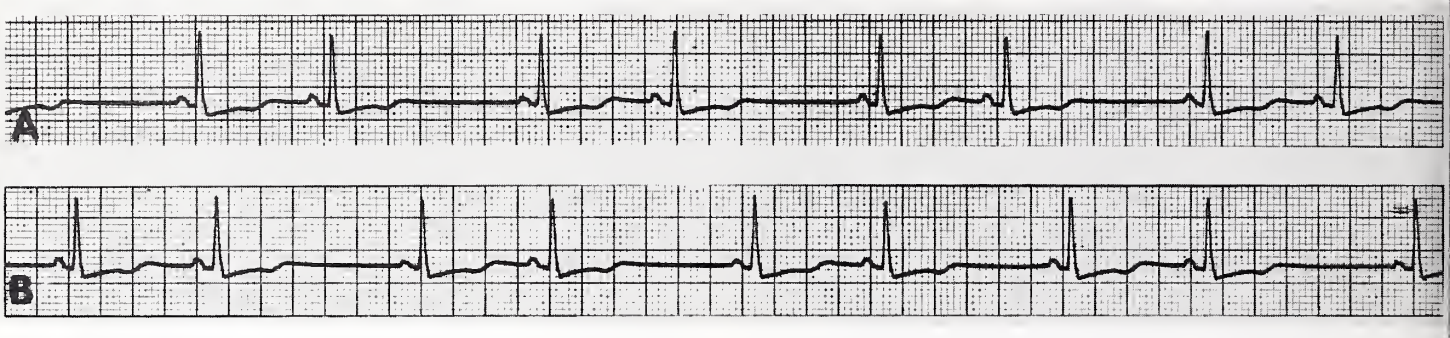

Strips A and B are a continuous recording of lead I from an elderly woman who was admitted to the hospital because of clinical and chemical evidence of digitalis overdosage. Other ECG leads showed a similar bigeminal pattern that persisted for nearly 48 hours despite withdrawal of the drug and potassium supplementation.

Inspection of this tracing reveals a repetitive bigeminal pattern of short (830 msec.) and long (1280 msec.) cycles. P-waves and PR intervals are identical as are the QRST complexes. Differential diagnosis of this arrhythmia includes atrial premature impulses, both blocked and conducted, sinus arrhythmia, fixed (3:2) sino-atrial block, 3:2 sino-atrial block of the Wenckebach variety[1] and "sinus" premature impulses.[2]

Conducted atrial premature impulses are unlikely because the P-waves are identical in contour and duration, and the PR intervals are constant. Blocked atrial premature impulses are ruled out because careful inspection of the ST-T waves of the second member of the pair fails to disclose ectopic P-waves buried within them. Sinus arrhythmia is dismissed because the typical, gradual alterations in cycle length are absent, and there is no phasic relationship to respiration.

There remain three possible interpretations which are often difficult to distinguish.[2] A regular or fixed 3:2 sino-atrial block is a rare conduction defect that is manifested by bigeminal, identical P-waves where the longer P-P interval is precisely twice the shorter P-P interval. This is clearly not the case in the illustration since the longer cycles (1280 msec.) are considerably less than twice the shorter cycles (830 msec.); 3:2 sino-atrial block of the Wenckebach variety is a more common arrhythmia seen in the setting of digitoxicity, carditis and inferior infarction.[1] Here, the second sinus impulse is conducted through the sino-atrial junction with a longer conduction time than the first, and the third impulse is blocked. Because the inscription of the second P-wave is delayed, the long interval containing the non-conducted P-wave will be shorter than twice the basic intersinus interval, i.e., the increased conduction time of the second P-wave will encroach upon and shorten the longer interval. Both fixed and Wenckebach-type 3:2 sino-atrial block result in bigeminal, sinus P-waves, but in the former the longer P-P interval is exactly twice the shorter, while in the latter the longer P-P interval must be less than twice the shorter. A third, rare possibility is "sinus" premature impulses engendered by foci somewhere in the vicinity of the sino-atrial node presenting as premature P-waves whose contour, duration and polarity are identical to those of sinusal origin. "Sinus" premature impulses also can occur in a bigeminal pattern and must be distinguished from 3:2 sino-atrial block of the Wenckebach variety. As illustrated lucidly by Schamroth, in 3:2 sino-atrial block, the P-P interval during normal sinus rhythm equals the shorter P-P interval during the bigeminy, while in "sinus" premature impulses the P-P interval during normal sinus rhythm equals the longer P-P interval in the Bigeminal rhythm.[2]

Regrettably, my patient developed atrial fibrillation soon after this tracing was recorded so that the "normal" intersinus interval could not be measured. Finally, this rare bigeminal pattern might be interpreted as 3:2 sino-atrial block with Wenckebach sequences or as alternate "sinus" premature systoles.

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Human Protein Requirements*

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Next to water, protein frequently is considered the quintessential nutrient, since it is the most essential constituent of cell metabolic components. The protein content of the adult human body is approximately 12 kilograms, half of which is contained in the body cell mass. The predominant protein mass of the body that requires dietary protein for replenishment of indispensable amino acids is the lean body mass (i.e., fat-free muscle, viscera and connective tissue). The protein content of the human body is constantly undergoing synthesis and breakdown. The rates and directions of these processes in the various tissues are dependent upon many factors, including the age and physical condition of the subject, the dietary intake of calories and protein, and physiological and pathological occurrences, i.e., starvation, infection, stress and disease.

The liver and muscle proteins, which constitute a major part of the body cell mass, are synthesized from dietary amino acids and amino acids provided from tissue protein breakdown. Surplus amino acids are used to produce carbon skeleton molecules or are broken down into carbon dioxide, water, energy and nitrogen-based radicals for excretion or utilization in other compounds. In the liver, the amino group is converted to urea and subsequently excreted in the urine.

Protein nitrogen is lost continuously through the urine, feces and skin, as well as through hair and nail losses. The daily protein supply for tissue protein synthesis, therefore, must be replenished continuously.

Dietary requirements for protein nitrogen include a need for certain amino acids which cannot be synthesized in the body. These are called essential or indispensable amino acids (EAA). For humans there are eight essential amino acids; however, infants and stressed older humans require an additional amino acid. Nonessential amino acids can be synthesized in the body.

The nutritional value of a specific dietary protein depends on the relative quantities of all the amino acids it contains. Dietary proteins which contain all the essential amino acids in sufficient amounts and proportions to each other are considered to be *complete* or *high-quality proteins.*[1] These proteins provide all the amino acids in the proportions needed by the body for growth and tissue maintenance. Proteins from animal sources (meat, milk, eggs, and others) are examples of high-quality proteins.

Proteins from individual vegetables and grains tend to have *incomplete* patterns of essential amino acids, i.e., they are generally deficient in one or more essential amino acids and are, therefore, of lower quality. Although individual vegetable and grain proteins are of lower quality, *mixtures* of these proteins can result in a total protein intake of higher nutritional quality than the components themselves.[1] This occurs when the deficient or limiting essential amino acid in one food source in an individual's diet is offset by the presence of that amino acid consumed in another food. For example, wheat products which are deficient in lysine, have moderate quantities of methionine; legumes, however, have an inverse ratio of these essential amino acids. When these two protein sources are consumed in the same meal, the proportions of lysine and methionine will be balanced out, yielding a meal with a higher protein quality than either individual protein would yield. Thus, vegetarians who select a diet containing a wide variety of foods are able to maintain adequate protein synthesis and avoid protein deficiency.

Utilization of dietary amino acids for protein synthesis by the liver occurs during the absorption from the intestine. Both human and animal studies have demonstrated impairment of liver protein synthesis during this absorptive period if tryptophan is not consumed in the same meal with the other essential amino acids. The evidence is less clear in regard to impairment of the synthesis of human liver proteins as a result of a short term (i.e., less than 24 hours) dietary limitation of any one of the other essential amino acids.[2]

It is important to realize that the ability of protein to meet the requirement of nitrogen balance is not only a function of biological value, but is also a function of the total amount of protein taken in. Thus, while 27 to 30 grams (g) of a vegetable protein mixture may not be adequate for nitrogen balance, feeding this same vegetable protein at a normal intake of 75 g/day can produce nitrogen balance and be as acceptable a protein source as "higher biological value" protein. Nitrogen balance is also dependent on other important variables: the availability of nonprotein calories (particularly carbohydrate), age of a person and severity of disease. A number of techniques are available to determine the protein quality of a given food and are described in detail elsewhere.[3]

DETERMINATION OF PROTEIN REQUIREMENTS

Human protein requirements have been investigated in-

*Reprinted with permission of Contemporary Nutrition 5:1 (Jan) 1980, a newsletter from the Nutrition Department of General Mills, Inc., Minneapolis. Dr. Blackburn and Mr. Palombo are affiliated with the Nutrition/Metabolism Laboratory, Cancer Research Institute, New England Deaconess Hospital/Harvard Medical School, Boston.

tensively over the past 50 years using either the Factorial Method or the Nitrogen Balance Method.[4] Protein requirements vary from individual to individual according to age, diet, environmental factors, pathological conditions, and others.[4] For example, on a body weight basis, the amount (grams) of protein required per kilogram body weight (kg. B.W.) decreases with age.[5] Furthermore, the proportion of dietary protein that must be supplied as essential amino acids decreases with age; while 32 percent of total estimated protein requirements in children should be supplied as essential amino acids, adults only require 15 percent as essential amino acids.[4] In other words, on a body weight basis, adults require 78 milligrams (mg)essential amino acids per kg B.W. daily, whereas children require 214 mg essential amino acids per kg B.W.[5] Thus, dietary proteins appear to be used more efficiently by adults in meeting requirements than by children.

Stress, infection and heat can cause increased nitrogen loss and increased protein requirements. Heavy work or intensive physical training exercises causes an increase in muscle mass.[6] Therefore, athletes in training may have a slight increase in protein requirements.

In the U.S., these protein needs undoubtedly will be met by dietary means, since 97 percent of healthy Americans consume much more protein than is required; the amount of extra dietary protein consumed may approach 40 to 50 g per day.[7]

ENERGY INTAKE AND PROTEIN REQUIREMENTS

Standard estimates of protein requirements are valid only when energy needs have been met. When energy intake is inadequate, some dietary and tissue protein will be oxidized or converted to glucose in the liver to meet energy needs. When energy intake levels are marginal, protein needs are higher than during periods of satisfactory energy intake.[8] This may be due to relative changes in activities or concentrations of key enzymes responsible for degradation of EAA and an obligatory requirement for energy substrates from amino acids. Thus, efficiency of nitrogen utilization, which in turn affects protein requirements, is dependent upon the total calorie intake and energy requirements.[9]

RECOMMENDED DIETARY ALLOWANCES

Since protein requirements for a given age, weight and sex group vary widely according to the previously discussed factors, recommended protein intakes had to be set substantially higher than minimum needs in order to cover the needs of the greater majority of individuals within these groupings.

The Recommended Dietary Allowances (RDA) for protein in adults (23 to 50 years of age) are based on results from nitrogen balance studies which determined the average maintenance requirement for nitrogen as protein.[10] This amount, which is 0.47 g protein/kg B.W., is increased 30 percent to cover individual variability. The efficiency of protein utilization (75 percent) in the average U.S. diet is then considered; thus 0.8 g protein/kg/day (56 g for a 70 kg male, and 44 g for a 55 kg female) is derived as the daily protein allowance. Pregnant and lactating women have higher protein allowances—an extra 30 g and 20 g, respectively. The 1973 Technical Report #522 by FAO/WHO on energy and protein requirements recommended lower intakes based on egg or milk protein: 0.57 and 0.52 g protein/kg for adult men and women, respectively.[3] This report further suggested that a correction for dietary protein quality might be necessary for certain age groups or individuals on certain diets. Therefore, a diet consisting primarily of low-quality protein would necessitate increasing the recommended intake of protein to a new "safe" level. Problems in the interpretation and use of dietary standards have been reviewed elsewhere.[1]

PROTEIN INTAKE IN THE UNITED STATES

In the U.S., approximately 15 to 17 percent of the total caloric intake is in the form of protein, which is equivalent to 90 to 100 g/day.[12] Since minimal protein needs for healthy adults are 35 to 40 g/day, and the RDA are 44 to 56 g, it easily can be understood why protein supplements are superfluous and are mainly an expensive source of energy. The findings from various U.S. government nutrition surveys such as the Ten-State Nutrition Survey, the Health and Nutrition Examination Survey (HANES), and the new U.S. Department of Agriculture (USDA) Nationwide Household Food Consumption Survey indicate that the vast majority of Americans receive adequate dietary protein for body maintenance and good health, and that protein deficiency is a rare condition in the United States. It is also known that the quality of protein consumed has changed since 1900.[12] More than two-thirds of dietary protein comes from animal sources today, as opposed to one-half seventy years ago which reflects a greater grain consumption at that time.[12] In terms of achieving a high-fiber, low-fat diet which has been suggested by some health professionals for improved health, a shift toward increased consumption of grain and vegetable proteins is desirable.

Since some elderly individuals suffer from various socio-economic and disease conditions which may lead to poor eating habits, special consideration has been given to the adequacy of their diet in terms of the major nutrients. The Ten-State Nutrition Survey reported that while total nutrient consumption among the elderly tended to be below the 1968 RDA, protein intakes met or exceeded the RDA in the majority of instances.[7] Furthermore, recent metabolic studies on protein requirements in the elderly concluded that a typical American diet with its high protein content should be adequate for this age group.[13] Certain elderly ethnic groups, e.g., black and Spanish-American women in high income states, had mean protein intake levels below the RDA. This observation, however, does not necessarily signify the existence of protein malnutrition among these people, since RDA are set well above minimum requirements.

An evaluation of the protein intakes of various groups of vegetarians demonstrated that "pure" vegetarians (vegans) were receiving about 83 grams of dietary protein/day while the lacto-ovo vegetarians (i.e., including milk and eggs) consumed about 98 g/day.[14] A more recent report confirmed that vegetarian diets contain adequate protein levels when the diet is selected from a wide variety of vegetables, grains, nuts and fruits.[7]

PROTEIN NEEDS AND WEIGHT REDUCTION

Information also is available on the protein needs of subjects who are on strict weight- reduction regimens which require fasting or starvation. Without an exogenous source of calories the body must use its endogenous reserves of fat and protein primarily to meet energy requirements. In short-term starvation the body adapts to the caloric deprivation by using muscle protein and adipocyte fat as its primary source of calories. In long-term starvation (longer than two weeks), the body begins conserving protein and calories are derived primarily from fat.[15] Protein losses are continuous, however, and replenishment is vital to ensure survival. Obesity therapy

regimens which use long-term unsupplemented fasting may jeopardize the subject's health through excessive loss of functional tissue proteins, minerals and vitamins. Supplemental fasting modified by administration of dietary protein, i.e., "protein-sparing therapy,"[16] in part enables the fasting subject to attenuate nitrogen loss and achieve nitrogen equilibrium.[17] High-quality protein (e.g., fish or fowl) is administered at 1.2-1.4 g/kg ideal body weight along with vitamins and trace elements. This protein intake cannot be substituted by nonprotein calories and still produce the same nitrogen balance. Protein clearly is essential to preserving body cell mass during hypocaloric feeding and severe calorie-restricted diets for treatment of obesity. While low-biological proteins may be capable of maintaining nitrogen balance when given in large amounts,[18] they have not been tested adequately as a protein source for unsupervised diets.

As of June, 1978, 58 deaths had occurred that were associated with the use of very low calorie, protein diets.[19] Sixteen of these deaths were due to development of cardiac arrhythmias and arrest in obese, but otherwise healthy, women who were reducing their body weight by strict adherence to a fasting regimen supplemented daily with small (3 to 5 oz.) quantities of predigested liquid protein products. The etiology of these cardiac arrhythmias could not be determined by investigators from the Food and Drug Administration (FDA), Center for Disease Control or an Ad Hoc committee of scientific experts convened by the FDA. While there is support for the hypothesis that these deaths were due to severe caloric restriction and starvation, the most likely explanation is that deficiencies of certain essential minerals (i.e., potassium, magnesium and phosphate) developed. Seven of these 16 deaths occurred during carbohydrate refeeding, a period in which significant metabolic changes from the starvation state occur (i.e., increased sodium and water retention, increased insulin production, and altered intracellular enzyme activity and breakdown rates of muscle and adipose tissue).

STRESS, INJURY AND INFECTION

Protein requirements may be greatly increased during episodes of stress, infection and injury. Alterations in the body protein metabolism are generally aimed at mobilizing skeletal muscle proteins to ensure an adequate supply of substrates for energy production and protein biosynthesis. This catabolism of muscle proteins is triggered by hormonal changes, such as increased catecholamine and glucocorticoid secretion into the bloodstream, resulting in an overall negative balance.[20] The degree of nitrogen loss is dependent upon the severity of infection or injury; obligatory losses may approach the equivalent of 0.9 g protein/kg/day.[21] Thus, prolonged infection and injury without adequate nutritional support will lead to protein malnutrition, as has been observed in hospitalized adult patients.[22] Basic oral anabolic diets for depleted patients have been described.[23] The protein-nitrogen content of these diets should be considered independent of calorie content. Nitrogen: calorie ratios are not instructive in designing dietary therapy. At a caloric intake of 45 Kcal/kg/day, the desirable protein intake would be 1.8 g/kg/day to allow for optimal nitrogen utilization. At these levels, the ratio of nitrogen to calories is approximately 1:150. Special considerations for patients with liver or renal disease must be taken into account in terms of protein requirements.[23] During acute phase of injury, nitrogen intake may need to be further increased without an increase in nonprotein calories.

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Medical Services for the Elderly

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The need for a varied and flexible system of medical services for the elderly is a major concern of the medical community, the elderly and, increasingly, the federal government. It is neither necessary nor feasible to stress one form of care over others in meeting the specialized health care needs of older Americans although that has been the case for more than a decade.

The advent of Medicare in 1965 was heralded by many as the most workable means of helping older people meet their health care expenses without the fear of financial hardship. Medicare has done much to help older people stay healthy and solvent but it has many gaps that should be filled to protect both the health and pocketbooks of older health care consumers.

Medicare was designed to help defray the cost of hospitalization and other forms of acute health care since these are the most costly. Consequently, the Medicare program was geared more toward accomplishing these aims than offering a variety of related services to the elderly.

Health care experts contend that with the advances made in the development and delivery of acute care as well as its availability to Medicare beneficiaries, other forms of less comprehensive medical services are necessary as a corollary.

Due to the success of the Medicare program as a means of providing medical services to the elderly, Congress has a good deal of interest in the scope and direction taken by the government in providing health care services to certain segments of the population. Of necessity, the most time and effort spent on analyzing health care needs have been directed toward those programs designed for the elderly.

There are 22 million plus people in the United States over the age of 65. Projections for the next decade indicate a substantial increase in the elderly population. The over-75 and over-85 age groups are growing more rapidly than any other in the country. However, long-range projections show a leveling off of the elderly population in approximately 50 years due to changes in the birth rate. This is an extremely important factor to keep in mind as future health care delivery needs are assessed.

Since the elderly are the major users of health care services, it becomes imperative that ongoing evaluations of the existing programs take place to make sure that older people are adequately served.

By all indications they are not. While this in itself is not a startling revelation, this fact takes on added significance when the government's share of the total health care bill is totaled. In 1978, the United States government spent $41 billion on health care for the elderly. Unless certain steps are taken to reverse this trend, billions of dollars will continue to be spent on expensive, but in too many cases, inappropriate care.

Medicare and Medicaid, the two largest and most expensive government health programs, unduly stress institutionalization over other alternatives such as home health care.

A good example of the built-in bias toward institutionalization in the Medicare program is the three-day prior hospitalization requirement before home health benefits can begin. In other words, an individual who needs to avail himself of certain services best provided in a home setting must be hospitalized in order to qualify for the home-health benefits in the program. Not only does this unnecessary institutionalization add to the nation's total health care bill, it becomes the only health care option available to many older persons who lack the financial resources to pay for other forms of care. Neither the physicians nor the elderly are at fault in cases such as these because there is no choice.

If the overreliance on institutionalization continues unabated, many more expensive and specialized facilities will have to be constructed to take care of the large volumes of patients. Construction of such magnitude would require enormous expenditures of capital and also would represent an imprudent commitment of our resources for long-term care facilities not required by a changing population. These facilities would be difficult to convert to other uses after the initial demand for them subsides.

With this in mind, it becomes essential that Congress move swiftly and decisively to amend the Medicare and Medicaid programs so that they will be more able to meet the needs of their participants.

Both Medicare and Medicaid provide a limited number of home health visits if the beneficiary is essentially confined to his home, under the care of a physician and in need of skilled nursing care, speech therapy, or physical therapy. Unfortunately, the limit on the number of days permitted under both parts of the Medicare program rules out this option for many potential home health patients. There is also a cost-sharing requirement of $60 which must be paid by the patient

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*Congressman from the 2nd District. He is a member of the Committee on the Judiciary, the Committee on Merchant Marine and Fisheries, and the Select Committee on Aging. He may be addressed at 436 Cannon House Office Building, Washington, D.C. 20515.

under part B of Medicare. The cost-sharing requirement often presents financial difficulty for the marginally poor older patient. Restrictions on home health care visits are basically the same for Medicaid patients except for the cost sharing.

Once the Medicare patient has used up his allotted number of home-health visits, he may find himself back in a hospital or relegated to a nursing home although neither of these two forms of care might be the best alternative. In some situations, the Medicare patient's future is even more bleak.

Countless incidents have been documented where the patient is simply sent home to fend for himself, often with disastrous consequences. Clearly, our present health care initiatives are not flexible enough to make them a valuable part of a diversified medical services' delivery system.

Congress has taken steps toward revamping the Medicare program to make it more responsive to the needs of its beneficiaries. Legislation has been drafted and hearings have been held on proposals to remedy the present state of affairs. As a result, Congress will be voting on legislation to make home health care a more realistic and reliable component in the total health care delivery system.

The Medicare Act Amendments will eliminate the number of home health-care visits allowed under parts A and B of Medicare. The three-day prior hospitalization requirement will be waived under part A. This is an important provision for the 1.1 million Medicare beneficiaries who have only part A of Medicare insurance. Finally, the bill will remove the $60 deductible with respect to home health services. This last change will make home health care more attractively financially to the Medicare patient. It is expected that upon enactment of this bill, substantial savings will accrue to Medicare beneficiaries as well as the taxpayers. As the number of Medicare patients increases in the near future, this important aspect should not be downplayed.

While the thrust of the Medicare Act Amendments is directed toward liberalizing home health benefits, another significant provision should be mentioned, the use of swing beds.

Medicare and Medicaid patients now are allowed to stay in hospitals when there is available space after the acute care has been administered but must remain in special areas where beds are reserved for nursing care patients. This requirement is difficult to meet for many hospitals. The legislation under discussion would ameliorate the situation by removing this restriction. In New Jersey, where there is a shortage of nursing home facilities, unoccupied hospital beds could be put to good use for older persons who would not be good home health candidates.

The most noticeable progress in Congress has been directed toward amending the Medicare Act, but legislative improvements in the Medicaid program are also under way. The Medicaid Community Care Act has been proposed to deal with many of the problems that have arisen over the years with the Medicaid program.

The emphasis on institutionalization so evident in the Medicare program is even more pronounced in Medicaid. The Medicaid program is growing more rapidly than any other in the entire array of federal health care efforts. This alone justifies a long hard look at the direction Medicaid is headed.

Since 1970, states have been permitted to provide some home health services to Medicaid patients but they are also allowed to restrict the number of visits and the scope of care involved. Individuals with incomes low enough to qualify for Medicaid assistance in general may be slightly over the limits in qualifying for home health benefits. As a result, these individuals are sent to nursing homes, intermediate care facilities or hospitals at a much higher cost and place an inordinate strain on such facilities.

Perpetuation of this system will lead to many of the same problems that have occurred with the present Medicare restrictions on home health care. In fact, Medicaid restrictions mean greater fiscal burdens on the treasury because the costs incurred in the Medicaid program are not shared by the patient.

As a means tested program, Medicaid lends itself to unintended abuses. Many individuals liquidate their assets so that they will be able to take advantage of the comprehensive coverage provided by Medicaid. Although this practice was not intended in the original law, it takes place with great regularity and ends up costing the government and the taxpayers quite a bit of money.

If the current law is not altered, the Congressional Budget Office estimates that by fiscal year 1985, approximately $43 billion will be spent by the Medicaid program for care provided in skilled nursing facilities. This is about three and one-half times the amount spent for nursing home services in fiscal year 1977.

By making home health services available to Medicaid beneficiaries where appropriate, and doing away with the need to liquidate assets in order to meet the eligibility requirements, the cost of the program could be decreased. The General Accounting Office, the congressional watchdog agency, concurs with this assumption.

The Community Care Act would make participation in the program voluntary for the states. However, surveys of the states indicate a willingness to participate. Safeguards are contained in the legislation to make certain that the states involved in the program would not spend more than the rate set for nursing home care in each state. By keeping the program voluntary, the necessary flexibility that is a key to the program's success, will be built in from the start.

Congress has the difficult task of dealing with rising health care expectations on the part of the American elderly while coping with dwindling financial resources and the necessity of balancing the federal budget. A tremendous amount of pressure has been brought to bear on federal legislators to accomplish these goals. For too long, it was assumed that providing more and diversified health care without increasing expenditures was an impossibility. Fortunately, this assumption is no longer dominant. Fewer funds earmarked for health care have spurred a drastic reassessment of the direction the federal government has taken in financing health care programs. The deficiencies in the present programs can and will be remedied upon enactment of legislation such as the Medicare Act Amendments and the Community Care Act.

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physicians Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

Workshop on Starting a Practice

"Starting Your Practice" a workshop designed for physicians going into private practice will be held on November 12th and 13th from 8:30 a.m. to 5:00 p.m. at the Sheridan Heights Hotel in Hasbrouck Heights. The Medical Society of New Jersey is cosponsoring the course as a membership service in co-operation with the American Medical Association.

The session, taught by AMA Department of Practice Management staff, has been attended by over 3,000 physicians nationwide. Accounting systems, collections, patient relations, insurance, medical records, appointment scheduling, and personnel are among the topics to be discussed. A special feature will be a segment on group and partnership practice opportunities.

Physicians completing residency training programs, leaving academia, the military, or large group practices may attend. Spouses are invited to audit.

Fees for the two-day session are: $120 for members of the AMA, MSNJ, or county societies; $160 for non-members; and $30 for spouses.

For further information or to register call the AMA collect: (312) 751-6667.

DOCTORS' NOTEBOOK

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

Through CMDNJ's short history, many of our faculty have gained recognition, both in this country and abroad, for their contributions to medical research, medical education and health care. One of the most prestigious of international honors, commonly called the Humboldt Award, has been bestowed upon a leading American scientist on our faculty who has served the CMDNJ-Rutgers Medical School since its inception and has contributed greatly toward the school's growth and development.

R. Walter Schlesinger, M.D., professor and chairman of the CMDNJ-Rutgers Medical School's microbiology department, was granted the Senior United States Scientist Award, as it is formally named, by the Federal Republic of Germany. Dr. Schlesinger was the first faculty appointee to the Piscataway-based medical school in 1963, which predates the formation of CMDNJ by seven years.

The Alexander von Humboldt Foundation, which gives the award it popular name, administers the award program for the West German government. The award was initiated in 1972 in memory of the 25th anniversary of the Marshall Plan, the post-World War II endeavor started by the then Secretary of State George Marshall to help stabilize and rebuild war-torn Europe.

Annually, the West German government allocates approximately $2 million to be granted to designated American scientists in recognition of career-long accomplishments. Some 50 of these scientists are selected each year. Besides a cash prize, the award entitles the scientists to undertake a research program at an institution in West Germany.

To be considered for a Humboldt Award, an American scientist first must be nominated by a West German scientist(s), or research institution or institution of higher learning. Dr. Schlesinger was nominated by three scientists at the Institute of Virology of the Justus-Liebig-University in Giessen, West Germany, where he began his six-month research program on October 1.

Included in the nomination criteria is the stipulation that the "scientific qualifications of the nominee must have gained him worldwide recognition, by virtue of success and echo of publication and invited speeches at significant conferences."

For Dr. Schlesinger, the award also gives him an opportunity to revisit his native land. He was born in Hamburg, Germany, in 1913, and has been a resident of the United States since 1938.

Dr. Schlesinger's work is well known among research scientists throughout the world. In the more than four decades since his graduation from the University of Basel (Switzerland) Medical School in 1937, his work in the fields of virology and microbiology has been documented in his 130 published articles, textbook contributions, research abstracts and scientific monographs.

Professional recognition of his contributions is not new to the distinguished scientist. For example, in the past eight years alone he has worked in England, Italy and West Germany under a Guggenheim Fellowship; was named the first Lloyd E. Rozeboom lecturer at Johns Hopkins University and, last year, received the Selman A. Waksman Award for contribution to his field from the New Jersey branch (Theobald Smith Society) of the American Society for Microbiology.

Dr. Schlesinger came to the CMDNJ-Rutgers Medical School, Piscataway, in 1963, following eight years as chairman of microbiology at St. Louis University School of Medicine. As the first faculty appointee to the school, which was then a new two-year basic sciences institution of Rutgers Universiity, he was responsible for much of its early growth, especially in regard to faculty expansion.

In the following years Dr. Schlesinger served in a number of academic and administrative roles in addition to his chairmanship. In 1970, as acting dean, he led the school through the transition that made it a part of CMDNJ, which had just been established by the state legislature. Under CMDNJ, the school soon expanded into a full, four-year M.D.-degree granting institution.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

The Health Care Financing Administration (HCFA) is considering the use of case-mix methods of payment for the Medicare cases throughout the country. The case-mix system is designed to identify the "intensity of services" required in the management of patients. Simply put, the more complex the problem, the more resources will be needed. Like all simplistic statements, it does not apply in all cases, since a lot of diagnostic and therapeutic services can be used on the wrong people for the wrong reasons. "Severity of illness," rather than "intensity of services," seems to be more accurate to many observers.

The label "case-mix" must be familiar to most readers, since it is the basis for the diagnosis-related group (DRG) program being instituted in New Jersey. According to the PSRO Letter, HCFA is examining DRG ". . . as the means for developing reasonable cost limits for all Medicare inpatient hospital expenditures."[1] Cases will be assigned to the appropriate DRG, and the average cost for each group will be identified. Next, the precentage of each hospital's cases in each DRG is established, plus the average cost of a DRG across all hospitals. The data thus gathered will be put into a classification which, HCFA believes, will permit fair reimbursement to hospitals, based on the severity of cases which the hospital treats.

This, in essence, is what is being undertaken by the New Jersey Department of Health. About 20 of the 1980 groups

of hospitals are on the system as of this writing, with the remaining six expected to start before the year ends. The next 40, to begin in January, have been announced. Discontent with some of the early billing experiences has appeared in the press.

A number of DRGs appear to be unrealistic, and revision of diagnoses and groupings is underway. Publication of utilization review (UR) regulations has prompted interested parties to try to become a "qualified utilization review organization." The payers will be responsible for, and will pay for, utilization review. The qualified UR organization could be the local PSRO, but it also could be another group. PSROs are obligated by law to review federal patients. It would seem consistent and less confusing to have the PSROs assume the UR tasks under DRG, which involves all hospital patients. If the PSROs do not review non-federal cases, who will? The regulations say that the Department of Health will allow no more than two review teams—the PSRO and another—in a hospital. New Jersey PSROs are negotiating with the Department of Health on this matter.

The fact that HCFA already is thinking of using DRG on a nationwide basis illustrates that they will consider any system that *appears* to be useful in reducing costs. DRG still does not have a validated track record, but there is eagerness to expand its use. The validity needs to be demonstrated: if the basic data are not accurate, the conclusion will be invalid, and rapid expansion will create more confusion. The House of Delegates of MSNJ adopted a resolution which emphasizes the priority of quality of medical care over cost savings alone. This needs to be reemphasized at every opportunity.

Another resolution adopted by the May 1980, House of Delegates calls for a moratorium on further implementation of DRG until the results of the first 26 hospitals can be evaluated. Such a delay is not likely to occur. The Department of Health is proceeding with its plans to put all hospitals on line by 1983, in order to implement S-446. Evaluations by MSNJ and NJHA (with the participation of NJFHCE) will be ongoing. No one can predict results of DRG or of S-446. The relationship between the rate-setting process and the planning programs (regionalization, certificate of need, HSA) must be kept in mind. All eyes are on New Jersey. The concept of payment by diagnoses, or consumption of resources, is being put to the test.

A Medicare notice in the *Federal Register,* on another matter, contains this interesting language: "we believe that to separately compute cost of care by degree of illness would lend itself to more and more fragmentation of the costs—a result that could significantly increase the complexity of reimbursement, without necessarily effecting more accurate reimbursement."[2]

Will DRG pull the fragments together or create more? No one knows at this point, but New Jersey physicians and their patients will have a front row seat.

References

[1]*PSRO Letter,* Vol. 8, No. 16. Washington, D.C., McGraw-Hill, August 15, 1980.

[2]*Federal Register,* Vol. 45, No. 161. Washington, D.C., U. S. Govt. Printing Office, August 18, 1980.

AMA's New Principles of Ethics

Preamble: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsiblity to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences with the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

CMDNJ Tenth Anniversary

Final preparations are being made for the gala celebration on November 15 which will highlight the year-long observation of the tenth anniversary of the College of Medicine and Dentistry of New Jersey (CMDNJ).

The Peter Duchin Orchestra has been engaged to furnish the music for dancing, and tickets are now available for the event, which will be held at Princeton University. As pointed out by Dr. Bergen, CMDNJ President, this is not a fund-raising event, which is reflected by the modest price of $60 per person for the evening—cocktails, dinner and dancing. Reservations can be made until November 1 through the CMDNJ Office of Public Affairs (201) 456-5000.

Under the theme "CMDNJ Celebrates New Jersey," the gala celebration will honor the state's four governors who were instrumental in the creation and growth of CMDNJ: Governor Brendan T. Byrne, Governor William T. Cahill, Governor Richard J. Hughes and Governor Robert B. Meyner.

Robert A. Beck, chairman of the board and chief executive officer, Prudential Insurance Company of America, and James E. Burke, chairman of the board, Johnson & Johnson, co-chair a blue-ribbon executive committee of 50 leaders in business and industry, as well as health care professionals and educators, to arrange the affair.

Those who attend will receive a copy of the special issue of the College's new publication, *The CMDNJ Journal,* which will contain a souvenir program insert. Featuring an in-depth narrative on the history and development of CMDNJ and spotlighting the individuals who played leading roles in the College's first decade, the magazine will serve as an excellent reference resource.

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Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Peter J. Arches, M.D., 150 Fayette Avenue, Apt. 2-H, Staten Island, NY 10305. University of East (Philippines) 1969. Board eligible. Group practice. Available.

CARDIOLOGY—James Liguori, M.D., 417 Union Avenue, Scotch Plains, NJ 07076. CMDNJ 1976. Board certified. Trained in all invasive and non-invasive techniques. Group, partnership, solo. Available July 1981.

Sheldon Eisenberg, M.D., 300 Community Drive, Manhasset, NY 11030. Cornell 1976. Also general internal medicine. Board certified (IM). Non-invasive techniques, hospital based, or single or multi-specialty group. Available July 1981.

DERMATOLOGY—Elliot C. Zweig, M.D., 14310 NE 5th Place, North Miami, FL 33161. SUNY-Downstate 1976. Also, general internal medicine. Board certified (IM). Partnership, group, associate. Available July 1981.

FAMILY PRACTICE—Leslie S. Rachlin, M.D., 1580 Four Mile Drive, Williamsport, PA 17701. Pittsburgh 1978. Group, partnership. Available July 1981.

C. Chin, M.D., 1016 Washington Garden Apts., Washington, NJ 07882. SUNY-Stonybrook 1979. Board certified. Part-time clinic, ER or housestaff duty. Available.

GASTROENTEROLOGY—Michael F. Fina, M.D., 134 North Street, Apt. 7, Newtonville, MA 02160. New York Medical College 1975. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available.

Abbasi Akhtar, M.D., 333 East Ontario Street, Apt. 1512-B Chicago, IL 60611. Liaquat (Pakistan) 1966. Also, general internal medicine and pediatric gastroenterology. Board eligible. Any type practice. Available.

GENERAL PRACTICE—Gregory A. Pistone, M.D., 2018 High Street, Haddon Heights, NJ 08035. Pennsylvania State 1979. Board eligible. Student health/adolescent medicine, pharmaceutical, ER, house physician. Available.

James Walter Warren, M.D., 67 Welton Street, New Brunswick, NJ 08901. Meharry 1973. Also general internal medicine. Any type practice. Available.

Chandrakant Patel, M.D., 4855 Vazina, Apt. #14, Montreal, Quebec H3W 1BQ Canada. Gandhi (India) 1970. Group, partnership, or solo. Available.

HEMATOLOGY/ONCOLOGY—P.S. Bala, M.D., 882-6 Clifton Court Circle, NE, Atlanta, GA 30329. Calicut (India) 1965. Board eligible. Any type practice. Available.

INFECTIOUS DISEASES—Richard M. Zweig, M.D., 9952 North Kendall Drive, No. 3-M, Miami, FL 33176. SUNY-Downstate 1976. Also, general internal medicine. Board certified (IM). Partnership, group,

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solo, or hospital-based. Available July 1981.

INTERNAL MEDICINE—Irwin Jaffe, M.D., 189-B Newport Road, Cranbury, NJ 08512. Zurich 1934. Board certified. Full or part-time industrial medicine or part-time with group. Available.

Peter Buch, M.D., 69-91 113th Street, Forest Hills, NY 11375. SUNY-Downstate 1976. Special interest, gastroenterology. Board certified. Group or partnership. Available July 1981.

Tej Mathur, M.D., 3071 Edwin Avenue, Apt. 3-C, Fort Lee, NJ 07024. Osmania (India) 1969. Special interest, cardiology. Group, partnership, solo. Available.

Lamberto M. Arellano, M.D., 45 Rocco Street, B-3, Belleville, NJ 07109. Santo Tomas (Philippines) 1973. Special interest, hematology/oncology. Board certified. Solo or partnership. Available July 1981.

Jacques A. Bataille, M.D., 1808 McDowell Avenue, Sharon Hill, PA 16146. Faculté de Medecine, Haiti. Solo, partnership, group. Available.

David Graber, M.D., 196 Howard Avenue, Passaic, NJ 07055. NYU 1975. Subspecialty, gastroenterology. Board certified. Group or solo. Available July 1981.

Lee A. Frankel, M.D., 63-B Cowperthwaite Street, Danbury, CT 06810. Guadalajara (Mexico) 1977. Board eligible. Solo, partnership, group. Available July 1981.

NEPHROLOGY—Jay I. Stack, M.D., 444 East 86th Street, Apt. 33-B, New York, NY 10028. University of Pennsylvania 1976. Also, general internal medicine. Board certified (IM). Group or partnership (willing to do general internal medicine). Available July 1981.

NEUROLOGY—Krishnababu Chunduri, M.D., 2121 Shore Parkway, Apt. 2-F, Brooklyn, NY 11214. Guntur (India) 1973. Board eligible. Solo or group. Available January 1981.

OBSTETRICS/GYNECOLOGY—T. L. Sharpe, M.D., 8309 SW 107th Avenue, Apt. D, Miami, FL 33173. Miami 1977. Board eligible. Group or partnership. Available July 1981.

ONCOLOGY—Pratima D. Parikh, M.D., 16 Wakeman Street, West Orange, NJ 07052. M.S.U. (India) 1973. Board eligible. Group, partnership, solo. Available.

OPHTHALMOLOGY—Mark Gorovoy, M.D., 1661 Kenwood Avenue, Alexandria, VA 22302. George Washington 1977. Board eligible. Any type practice. Available July 1981.

OTOLARYNGOLOGY—Samir M. Geleil, M.D., 94 Amith Street, Apt. 3-F, Brooklyn, NY 11201. Cairo (Egypt) 1965. Board eligible. Solo or group. Available July 1981.

PATHOLOGY—Doroteo A. Vicente, M.D., 36976 Farmbrook Drive, Mt. Clemens, MI 48043. Santo Tomas (Philippines) 1972. Both AP/CP. Board eligible. Group or partnership. Available.

Kung N. Rho, M.D., 5601 Boulevard East, Apt. 22-I, West New York, NJ 07093. Chonnam (Korea) 1959. Both AP/CP. Board eligible. Full or part-time group, institutional, or partnership. Available July 1981.

Kamini P. Vaidya, M.D., 956 Woodland Avenue, Oradell, NJ 07649. M.S.U. (India) 1971. Board certified (both AP and CP). Group, partnership, hospital. Available.

Syed A. Hadi, M.D., 162 N. Heck Hill Road, Saint Paris, OH 43072. Osmania/Gandhi (India) 1963. Board certified (AP), board eligible (CP). Any type practice. Available.

PEDIATRICS—Sunila Mehrotra, M.D., 829 Main Street, Apt. C, Belleville, NJ 07109. Delhi (India) 1974. Board eligible. Group/partnership. Available July 1981.

David R. Croughan, M.D., 12 Harbor Boulevard, East Hampton, NY 11937. Guadalajara (Mexico) 1973. Board eligible. Group, partnership. Available.

Joseph A. Weinberg, M.D., 29 Atwoodville Lane, Mansfield Center, CT 06250. Harvard 1973. Board certified. Group, partnership, associate. Available.

PSYCHIATRY—Alfredo J. do Pico, M.D., Azcuenaga 1152, Buenos Aires 1115, Argentina. Buenos Aires 1959. Board eligible. Partnership, group. Available.

PULMONARY DISEASES—Krishna Rao, M.D., 1575 Boston Avenue, Apt. C-9, Bridgeport, CT 06610. Osmania (India) 1973. Also general internal medicine. Board certified. Solo, group, hospital, partnership. Available.

RHEUMATOLOGY—John Guttell, M.D., 37 Putnam Road, Foxboro, MA 02035. NYU 1976. Board certified. Group or partnership. Available July 1981.

SURGERY, GENERAL—Craig J. Schaefer, M.D., 2507 North Upton Street, Arlington, VA 22207. Albany 1974. Board eligible. Group, solo, partnership. Available July 1981.

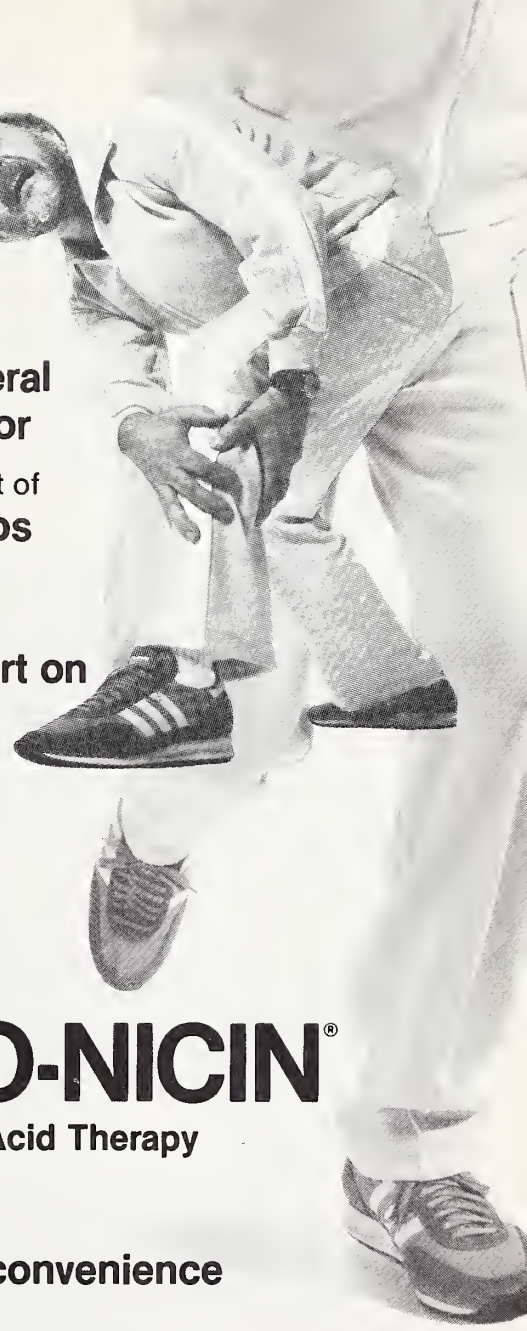
Mohammad A. Jabbar, M.D., 5103 Tiffany Place, 11315 Fondren Road, Houston, TX 77035. Guntur (India) 1966. Also, peripheral vascular surgery. Board certified. Solo, partnership, group (prefer solo). Available July 1981.

R. Nadaraja, M.D., 4B-2 Franklin Apts., Franklin Street, Morristown, NJ 07960. Ceylon 1967. Also, vascular surgery. Board certified. Group, partnership, solo, university. Available.

A. Bassal, M.D., 111 Grove St., #10, West Roxbury, MA 02132. Cairo (Egypt) 1968. Board eligible. Any type practice. Available.

SURGERY, VASCULAR—Pramod Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969. Board certified. Solo, group, associate. Available June 1981.

UROLOGY—Vijay S. Athani, M.D., 2009 Trent Court Apartments, Lindenwold, NJ 08021. L.T. Med. College (India) 1970. Board eligible. Solo, partnership. Available.



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LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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1980-1981
Special Committees and Liaison Representatives

Academy of Medicine of New Jersey

(1) Board of Trustees/Liaison Committee
(Liaison requested by Academy—6/19/66)
Alfred A. Alessi, M.D. ..... Hackensack
Robert W. Parvin, M.D. ..... Mount Holly
One appointment to be made
(2) Post-Graduate Medical Education Study Committee
(Representative requested by Academy—11/15/64)
Edwin W. Messey, M.D., *Chairman, Committee on Medical Education* ..... Willingboro
William Pomeranz, M.D., *Vice Chairman, Committee on Medical Education* .... Randolph Township

Agent Orange Commission

(Established by Governor—March 1980)
Laura E. Morrow, M.D. ..... Passaic

Aging, Advisory Committee to the Governor's Conference on

David Eckstein, M.D. ..... Trenton

Technical Committees established 7/15/80)

Health, Mental/Physical

David Eckstein, M.D. ..... Trenton

Retirement Roles

(appointments pending)

Aging, Family, Children, and Youth, Auxiliary Committee on

(Liaison requested by MSNJ's Auxiliary—11/19/72)
Edward L. Blackman, M.D. ..... North Brunswick

American Medical Association Education Research Foundation

(Liaison requested by AMA—10/7/51)
Palma E. Formica, M.D., *Chairman, Committee on Medical Student Loan Fund* ..... Old Bridge

Audit Review Committee (1979-1980 Audit)

(Appointed annually by Board to review previous year's audit)
Armando F. Goracci, M.D., *Chairman* ..... Woodbury
Frank Campo, M.D. ..... Trenton
Anthony P. De Spirito, M.D. ..... Neptune City
Myles C. Morrison, Jr., M.D. ..... Morristown
Howard D. Slobodien, M.D. ..... Perth Amboy
Consultants:
Rudolph C. Gering, M.D., *Treasurer* ..... Pennington
Richard E. Lang, M.D., *Chairman, Committee on Finance and Budget* ..... Passaic
William Greifinger, M.D., *Vice-Chairman, Committee on Finance and Budget* ..... Belleville

Blindness, New Jersey Society for the Prevention of

(Requested by the Society for the Prevention of Blindness—3/19/78)
Vincent B. Pica, M.D., *Chairman, Committee on Conservation of Vision* ..... Trenton

Blood Bank Association, New Jersey

(Liaison requested by New Jersey Blood Bank Association 4/25/69)
Frank Campo, M.D. ..... Trenton

Blue Cross-Blue Shield Plans of New Jersey Permanent Committee on

(Appointment of committee requested by MSP—4/16/60)
William Greifinger, M.D., *Chairman, Board of Trustees* ..... Belleville
Augustus L. Baker, Jr., M.D., *President* ..... Dover
Mr. Vincent A. Maressa, *Executive Director* ..... Lawrenceville
Equal Representation from:
Medical-Surgical Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association

Board of Institutional Trustees, Department of Human Services

(Appointed by Governor for 8-year term)
Thomas S. Bellavia, M.D. ..... Hasbrouck Heights
(appointment pending)

Bureau of Investigation, Department of Law and Public Safety

(Cooperating committee requested by Department of Law and Public Safety—9/61)
Members of the Board of Trustees who agree to participate (at the request of the State Board of Medical Examiners on 5/31/78, physicians specializing in internal medicine.)
David Flinker, M.D. ..... Moorestown
Frank J. Malta, M.D. ..... Toms River

Cardiovascular Advisory Panel to Director of Motor Vehicles

(Panel requested by Special Commission on Traffic Safety —9/17/61—appointed by Director of Motor Vehicles)
James G. Kehler, M.D. ..... Woodbury

Cervical Cancer Project Advisory Committee

(Requested by NJ Department of Health 6/6/79)
Gerald F. Hansen, M.D. ..... Hackensack

College of Medicine and Dentistry of New Jersey, Foundation of the

(MSNJ representative appointed yearly by the Board of Trustees to serve as a trustee, pursuant to the Bylaws of the Foundation)
Arthur Bernstein, M.D. ..... South Orange

Commissioner's Medical Advisory Committee

(Requested by State Commissioner of Health—6/15/77—to assist in the diagnosis-related group concept (DRG)
Alfred A. Alessi, M.D. ..... Hackensack
Augustus L. Baker, Jr., M.D. ..... Dover
Frank Campo, M.D. ..... Trenton
John S. Madara, M.D. ..... Salem
James S. Todd, M.D. ..... Ridgewood
Frank Y. Watson, M.D. ..... Montclair

Consumer Health Education, Advisory Committee of the Office of

(College of Medicine and Dentistry of New Jersey)
Howard D. Slobodien, M.D. ..... Perth Amboy

Crippled Children Commission, State

(Appointed by Governor for 5-year term)
Harry W. Fullerton, Jr., M.D. ..... Carney's Point

Discharge Planning, Task Force Committee on

(Representation requested 6/6/80)

Two appointments to be made

Disputed Claims, Advisory Committee to Review MSP and HSP

(Committee appointed by MSNJ with the concurrence of the New Jersey Hospital Association, per Board of Trustees 7/16/78)
Robert H. Stackpole, M.D., *Chairman* ..... Elizabeth
Donald P. Burt, M.D. ..... Morristown
Frank Campo, M.D. ..... Trenton
John J. Crosby, Jr., M.D. ..... Jersey City
Armando F. Goracci, M.D. ..... Woodbury
Frank J. Hughes, M.D. ..... Gloucester
Adolph R. Wichman, M.D. ..... Denville
Frank A. Wolf, M.D. ..... Phillipsburg

Education, State Department of

(Liaison requested by the Assistant Commissioner of Education—9/21/58)
Glenn P. Lambert, M.D., *Chairman, Special Committee on Child Health* ..... Flemington

Epilepsy, Advisory Panel to State Director of Motor Vehicles

(Established at request of Director of Motor Vehicles —7/29/66)
J. Berkeley Gordon, M.D. ..... Rumson

Executive Committee

(Provided in the Bylaws, Chapter III (c)
Augustus L. Baker, Jr., M.D., *President (Chairman)* ..... Dover
Armando F. Goracci, M.D., *President-Elect* ..... Woodbury
Howard D. Slobodien, M.D., *First Vice-President* ..... Perth Amboy
Alexander D. Kovacs, M.D., *Second Vice-President* ..... Scotch Plains
William Greifinger, M.D., *Chairman of the Board of Trustees* ..... Belleville
Alfred A. Alessi, M.D., *Immediate Past-President* ..... Hackensack
Arthur Bernstein, M.D., *Secretary, Consultant* ..... South Orange
Rudolph C. Gering, M.D., *Treasurer, Consultant* ..... Pennington

Graduate Medical Education, Advisory Council on

(Representation requested by CMDNJ)
Arthur Bernstein, M.D. ..... South Orange

Health Care Administration Board

(Appointed by MSNJ Executive Committee, per Board action 7/16/78)
Daniel J. O'Regan, M.D. ..... Lawrenceville

Health Maintenance Organization Projects, Advisory Committee to Participate in the Review of

(Recommended to Executive Director, State Health Planning and Coordinating Council, Department of Health)
Henry J. Mineur, M.D. ..... Cranford

Health Planning and Coordinating Council and/or its Review Committee, State

(Liaison established 1/15/78—appointed by MSNJ President)
*Howard D. Slobodien, M.D., *Second Vice-President* ..... Perth Amboy
*Appointed 5/79. Dr. Slobodien will serve in this capacity until he becomes President; at that time the new Second Vice-President will become his replacement.

Health Professions Education Advisory Council

(Department of Higher Education)
William J. D'Elia, M.D. ..... Spring Lake
Francis J. Pizzi, M.D. ..... Trenton

Hospital Association, New Jersey

(Liaison established at request of New Jersey Hospital Association—12/17/67)
Alfred A. Alessi, M.D. ..... Hackensack

Hospital Advisory Council, State Department of Health

(Appointed by the Commissioner of Health for an indefinite term)
Nicholas E. Marchione, M.D. ..... Vineland

House Maintenance, Staff Policies and Personnel Relations

(Special Committee created by Board of Trustees—9/21/58)
Augustus L. Baker, Jr., M.D., *President (Chairman)* ..... Dover
Armando F. Goracci, M.D., *President-Elect* ..... Woodbury
Howard D. Slobodien, M.D., *First Vice-President* . Perth Amboy
Alexander D. Kovacs, M.D., *Second Vice-President* ..... Scotch Plains
Alfred A. Alessi, M.D., *Immediate Past President* .... Hackensack
William Greifinger, M.D., *Chairman, Board of Trustees* ..... Belleville
Arthur Bernstein, M.D., *Secretary* ..... South Orange
Rudolph C. Gering, M.D., *Treasurer* ..... Pennington
Richard E. Lang, M.D., *Chairman, Committee on Finance and Budget* ..... Passaic
Mr. Vincent A. Maressa, *Executive Director* ..... Lawrenceville

Hypertension Study Group

(Department of Health)
Joseph A. Frashino, M.D. ..... Teaneck
(Dental Task Force—formed 6/80)
Micha Oren, M.D. ..... Randolph Township
(Pharmacy Task Force—formed 6/80)
Paul Goldfinger, M.D. ..... Dover

JEMPAC, Conference Committee with

(Established at request of JEMPAC—6/25/67)
Daniel J. O'Regan, M.D., *Chairman Council on Legislation* ..... Lawrenceville
Victor H. Boogdanian, M.D., *Chairman Council on Medical Services* ..... New Brunswick
Alexander D. Kovacs, M.D., *Second Vice-President* ..... Scotch Plains

Judiciary and Bar, Conference Committee on Inter-Relations with the

(Established at invitation of Supreme Court—11/17/63)
Augustus L. Baker, Jr., M.D., *President* ..... Dover
Armando F. Goracci, M.D., *President-Elect* ..... Woodbury
Howard D. Slobodien, M.D., *First Vice-President* ..... Perth Amboy
Alexander D. Kovacs, M.D., *Second Vice-President* ..... Scotch Plains
William Greifinger, M.D., *Chairman Board of Trustees* ..... Belleville
Arthur Bernstein, M.D., *Secretary* ..... South Orange
Rudolph C. Gering, M.D., Treasurer ..... Pennington
Daniel J. O'Regan, M.D., *Chairman Council on Legislation* ..... Lawrenceville
Michael J. Doyle, M.D., *Chairman, Committee on Medical Defense and Insurance* ..... Neptune
William J. D'Elia, M.D. ..... Spring Lake
James E. George,M.D. ..... Woodbury
Elmer L. Grimes, M.D. ..... Cherry Hill
Henry R. Liss, M.D. ..... Chatham

James S. Todd, M.D. ..... Ridgewood
Mr. Vincent A. Maressa, *Executive Director* ..... Lawrenceville
Mr. Joseph C. Lucci, *Director of Medical and Insurance Affairs* ..... Lawrenceville
Equal representation from:
Supreme Court Committee on Relations with the Medical Profession

Legislation

(1) Federal Keymen (Mechanism established by MSNJ—4/4/54—to serve as official intermediaries between MSNJ and the Federal legislators)
15 Congressional District Keymen
1 Senatorial Keyman
(2) State Keymen (Mechanism established by MSNJ—7/13/52)
Keymen in 15 Legislative Districts/21 Component Societies
List maintained by Council on Legislation and JEMPAC

Medical Assistance Advisory Council

(At the request of the New Jersey Department of Human Services, 1980)
William E. Ryan, M.D. ..... Pennington

Medical Assistants, (State of New Jersey) American Association of

(Liaison requested by Association—9/15/63
William J. D'Elia, M.D. ..... Spring Lake

Medical Liaison Committees

(High-level conference groups for discussion and consideration of items of mutual interest)
Augustus L. Baker, Jr.,M.D., *President* ..... Dover
Armando F. Goracci, M.D., *President-Elect* ..... Woodbury
Alfred A. Alessi, M.D., *Immediate Past-President* ..... Hackensack
William Greifinger, M.D., *Chairman, Board of Trustees* ..... Belleville
Mr. Vincent A. Maressa, *Executive Director* ..... Lawrenceville
(Where number of representatives from other organization is larger than number of MSNJ representatives, the latter will be increased from the Presidential Officers to equal the former.)
(1) Medical-Dental
(Liaison requested by the Dental Society—6/10/51)
(2) Medical-Hospital
(Liaison established by MSNJ—10/25/53
(3) Medical-Legal
(Liaison established by MSNJ—10/25/53)
(4) Medical-Nursing
(Liaison established by MSNJ—4/4/54
(5) Medical-Osteopathic
(Liaison requested by Osteopathic Association—9/17/61)
(6) Medical-Pharmaceutical
(Liaison established by MSNJ—7/26/53)

Medicare Peer Review Committee

(Established by Board of Trustees 12/20/70 at request of fiscal intermediary. Committee will review and evaluate claims involving questions of overutilization under Medicare. Composition of committee includes six groups of three members each in the fields of general practice, general surgery, orthopedic surgery, internal medicine, ophthalmology, and urology.)

Membership Inquiry and Complaint Mechanism

(Established at the 12/10/72 Special Session of the House of Delegates to deal more effectively with third party insurance carriers and government medical programs as they affect the practices of the membership.)

Membership Inquiry and Complaint Committee with Medical-Surgical Plan of New Jersey

Samuel Baum, M.D. ..... Passaic
Donald P. Burt, M.D. ..... Morristown
Arthur C. Dietrick, M.D. ..... Mount Holly
Karl T. Franzoni, M.D. ..... Trenton
James E. George, M.D., J.D. ..... Woodbury

Membership Inquiry and Complaint Committee with Medicare

William H. Coleman, M.D. ..... Trenton
Richard H. DuPree, M.D. ..... Woodbury
Andrew G. Hudacek, M.D. ..... Morristown
Joseph W. Schauer, Jr., M.D. ..... Farmingdale

Membership Inquiry and Complaint Committee with Medicaid

John J. Crosby, Jr., M.D. ..... Jersey City
Michael J. Doyle, M.D. ..... Neptune
Armando F. Goracci, M.D. ..... Woodbury
Robert E. McNamara, M.D. ..... Elizabeth
B. Ralph Wayman, Jr., M.D. ..... Morrisville, Pa.

Membership Inquiry and Complaint Committee with Other Health Insurance Carriers

Melvin J. Andrews, M.D. ..... Camden
Carl Minitti, M.D. ..... Gibbstown
Howard D. Slobodien, M.D. ..... Perth Amboy
Robert A. Weinstein, M.D. ..... Newton

New Jersey Health Sciences Group

(Membership requested by the Group 1/19/75)
Edward G. Bourns, M.D. ..... Jamesburg
Paul J. Hirsch, M.D. ..... Bridgewater
Bernard A. Rineberg, M.D. ..... New Brunswick

New Jersey Health Sciences Group Legislative Affairs Committee

(Liaison requested by the Group 11/16/75)
Daniel J. O'Regan, M.D., *Chairman Council on Legislation* ..... Lawrenceville

Nurses Association, Joint Practice Committee with the New Jersey State

(Reinstated by the Board of Trustees—4/18/79. Committee to consist of four M.D.s (to be appointed by the President), and four R.N.s (to be appointed by the Nurses Association).)
Charles S. Krueger, M.D., *Cochairman* ..... Mount Holly
Ms. Gloria Bruno, R.N., M.A., *Cochairman* ..... Emerson
Stanley Karp, M.D. *(M.D.-R.N. pair in joint practice)* ..... Cinnaminson
Ms. Barbara Medoff-Cooper, R.N., M.S.N. *(M.D.-R.N. pair in joint practice)* ..... Philadelphia
Carter Marshall, M.D., *Educator* ..... Newark
Shirley Smoyak, R.N., Ph.D., *Educator* ..... Edison
Palma E. Formica, M.D. (*Board member-at-large*) ..... Old Bridge
Ms. Roseanne Wille, R.N., (*Board member-at-large*) ..... Paramus
Mrs. Michelle Guzy, R.N., (*Alternate board member-at-large*) ..... Cherry Hill

Parents and Teachers, New Jersey Congress of

(Liaison requested by MSNJ's Committee on Child Health—12/20/64)
William J. Farley, M.D. ..... Brielle

Physician-Dentist Loan Redemption Program, Advisory Committee to New Jersey

(Appointed by the Chancellor of Higher Education)
Charles S. Krueger, M.D. (Delegate) ..... Mount Holly
Alfred A. Alessi, M.D. (Alternate Delegate) ..... Hackensack

Physicians' Assistant Program at CMDNJ—Rutgers, Advisory Committee on

(Appointed by Board of Trustees 7/17/77)
Arthur Krosnick, M.D. ..... Trenton

Radiation Protection Commission, Advisory Commission to New Jersey

(Two consultants in nuclear medicine requested by the Commission 11/66)

Melvin H. Freundlich, M.D. ..... Belleville
Henry J. Powsner, M.D. ..... Princeton
Theodore J. Stahl, M.D. ..... New Brunswick

Radiation Protection Commission, Consultant to New Jersey

(Nomination for appointment to Commission requested —7/18/65)

Frank Gingerelli, M.D. ..... Hackensack

Rehabilitation Services, Division of Vocational

(Liaison requested by MSNJ's Committee on Rehabilitation—5/65)

Daniel J. O'Regan, M.D. ..... Lawrenceville

Resolutions, Committee on Annual Meeting

(Established by Board of Trustees—7/18/71—to review all resolutions in advance of the annual meeting)

John S. Madara, M.D., *Chairman* ..... Salem
Charles S. Krueger, M.D. ..... Mount Holly
Alfred A. Alessi, M.D. ..... Hackensack

Safety Council, New Jersey State

(Provided in Council bylaws)

Augustus L. Baker, Jr., M.D., *President* ..... Mount Holly
Maurice E. Goldman, M.D., *President's Representative, Chairman, Special Committee on Occupational Health, Workmen's Compensation and Rehabilitation* ..... Linden

State Board of Medical Examiners

Trustees designated to attend monthly meetings on a rotating basis—per Board action 8/8/79

Armando F. Goracci, M.D., *President-Elect* ..... Woodbury
Mr. Martin E. Johnson, (MSNJ staff member)
Director, Public Affairs and Medical Education .. Lawrenceville

Student Association, MSNJ (Formed 7/17/77)

(Member of Board of Trustees—per Board action 10/21/79)

Palma E. Formica, M.D. ..... Old Bridge
Mr. Charles Spingola (Student) ..... Newark

Widows and Orphans of Medical Men of New Jersey, Society for Relief of

(Liaison requested by Society—5/17/59)

Joseph R. Jehl, M.D. ..... Clifton

NEW YORK UNIVERSITY

POST-GRADUATE MEDICAL SCHOOL

announces

INTERNAL MEDICINE BOARD REVIEW

JANUARY 7 to MAY 24, 1981 WEDNESDAYS 4 to 7 P.M.

COURSE DESCRIPTION

An improved method by which to prepare for either board certification or recertification in medicine. In an attempt to provide more effective retention of cognitive material, the Post-Graduate Medical School has decided to spread the basic and clinical information over a six-month time span with weekly three-hour sessions running from January through June, 1981.

Each teaching session is divided into two parts: 1) a brief summary lecture emphasizing the essential and relevant status of the area under discussion and 2) a self-assessment examination workshop based on questions found on certification and recertification examinations providing responses with explanations of appropriate and inappropriate answers. A principal goal of the course is to provide the reasoning behind the identification of responses to questions. At each session written material pertinent to the following week's subject will be distributed to the registrants.

In addition to physicians preparing for examination, those who desire a comprehensive yet concise review of recent and significant advances in medicine will find this course helpful in clinical practice.

PROGRAM TOPICS

CARDIOLOGY	ENDOCRINOLOGY	NEUROLOGY	NEOPLASTIC DISEASES	SKELETAL DISEASES
DIABETES	HEMATOLOGY	CLINICAL IMMUNOLOGY	PULMONARY DISEASES	DERMATOLOGY
GASTROENTEROLOGY	HYPERTENSION	INFECTIOUS DISEASES	NEPHROLOGY	

FACULTY

John J. Ackert	Charles N. Friedlander	Herbert J. Kayden	Stephen B. Richardson
Francis V. Adams	Arthur C. Fox	David L. Kleinberg	Herbert S. Samuels
Bertrand Agus	Stuart M. Garay	Itzhak Kronzon	Robert G. Schacht
Edward L. Amorosi	Richard M. Gilbert	Saul Krugman	Michael F. Schloss
Manfred Blum	Ephraim Glassman	H. Sherwood Lawrence	Robert Silber
Ronald Blum	Roberta M. Goldring	Jerome Lowenstein	Michael S. Simberkoff
Arthur D. Boyd	Melvin C. Gluck	Basil K. Lucak	Norton Spritz
Louis Buzzeo	H. William Harris	Sydney J. Mehl	Paul A. Tunick
Lynn C. Christianson	Charles G. Hazzi	Andrew M. Milano	Fred T. Valentine
Martin Dolgin	Charles S. Hollander	Franco Muggia	Arthur H. Weintraub
Eugene P. Fazzini	Robert S. Holzman	Robert A. Press	James C. Wernz
Henry N. Frey	Lois A. Katz	Marie Pulini	Stanford Wessler
	Thomas G. Kantor	James J. Rahal, Jr.	

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NJ 10/80

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Nov.

11 **Physics for the Anesthetist**
7:30 p.m.—Helene Fuld Medical Center, Trenton
(Helene Fuld Medical Center)

12 **Extracranial Cerebral Vascular Disease**
8-9:30 p.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

18 **Professional Liability and the Anesthesiologist**—Dinner Meeting
6 p.m.—Ramada Inn, Clark
(NJ Society of Anesthesiologists and AMNJ)

Dec.

9 **Anesthesia for the Obese Patient**
7:30 p.m.—Helene Fuld Medical Center, Trenton
(Helene Fuld Medical Center and AMNJ)

10 **Nerve Blocks of Upper/Lower Extremities**
8-9:30 p.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Nov.

5 **Otitis Media**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

5 **Blood and Blood Component Therapy**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(Columbus Hospital and AMNJ)

5 **Nephrology 1980**
8:40 a.m.-noon—Helene Fuld Medical Center, Trenton
(Helene Fuld Medical Center)

5 **Nutritional Aspects of Cancer Treatment**
26 **Beta Blockade and Its Many Uses**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

5 **Burns**
12 **Medical Lecture Series**
19 1-3 p.m.—Christ Hospital, Jersey City
26 *(Christ Hospital and AMNJ)*

5 **Internal Medicine and**
12 **Therapeutics**
19 9-11 a.m.—Roosevelt Hospital, Menlo
26 Park
(Middlesex General Hospital and AMNJ)

5 **Diabetes Mellitus**
8:30 a.m.-1 p.m.—Rutgers Medical School, Piscataway
(American Diabetes Association, NJ Affiliate, Inc. and AMNJ)

5 **Monthly Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(AMNJ Endocrinology Section)

5 **Adult Onset of Diabetes**
19 **Anxiety and Depression**
9-11 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

5 **Endocrine Conferences**
12 3:30-5 p.m.—Rotates between Newark
19 Beth Israel Medical Center, College
26 Hospital, Newark, and VA Medical Center, East Orange
(AMNJ Endocrinology Section)

5 **Medical Grand Rounds**
12 11:30 a.m.-1 p.m.—VA Medical Center,
19 East Orange
26 *(AMNJ Endocrinology Section)*

6 **Immunology '81**
13 4-6 p.m.—Institute for Medical
20 Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

6 **Medical Grand Rounds**
13 9:30-11 a.m.—Newark Beth Israel
20 Medical Center
(AMNJ Endocrinology Section)

7 **Renal Conferences in Nephrology**
21 2-3:15 p.m.—College Hospital, Newark
(Nephrology Society of NJ and AMNJ)

7 **Medical Grand Rounds**
14 11:30 a.m.-1 p.m.—College Hospital,
21 Newark
28 *(AMNJ Endocrinology Section)*

8 **Bleeding Diseases**
8:30 a.m.-5 p.m.—Rutgers Medical School, Piscataway
(AMNJ)

11 **Use/Misuse of Mechanical Ventilators**
25 **Gastrointestinal Update**
12 noon-2 p.m.—West Jersey Hospital, Camden
(West Jersey Hospital)

11 **Scleroderma and Dermal Disorders**
8-10 p.m.—Schering Corporation, Kenilworth
(NJ Dermatological Society and AMNJ)

11 **Peptic Ulcer**
8-9:30 p.m.—Shore Memorial Hospital, Somers Point
(SKF Laboratories and AMNJ)

12 **The New Antibiotics**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(Columbus Hospital and AMNJ)

12 **Basic Mechanisms in Asthma**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

12 **Hypercalcemia in Geriatric Patients**
2 p.m.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)

12 **Decreasing Cardiac Events Post-Infarction**
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(Dover General, Riverside and St. Clare's Hospitals and AMNJ)

12 **Cardiology Conferences**
26 3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick
(CMDNJ-Rutgers Medical School, Somerset County Heart Association and AMNJ)

13 **Renal Transplantation**
8-9 p.m.—Zurbrugg Memorial Hospital, Riverside
(Burlington County Medical Society and AMNJ)

13 **Small Parts Ultrasonography**
7:30-9:30 p.m.
(NJ Institute of Ultrasound in Medicine and AMNJ)

14 **ACP New Jersey Regional Meeting**
All Day—Meadowlands Hilton, Secaucus
(NJ Chapter, American College of Physicians, Bergen Pines County Hospital and AMNJ)

14 **The Zone Fasciculata in Human Hypertension**
4:30-5:30 p.m.—St. Barnabas Medical Center, Livingston
(St. Barnabas Medical Center and AMNJ)

17 **Clinical Cardiology**
7-8 p.m.—Paul Kimball Hospital, Lakewood
(Paul Kimball Hospital and AMNJ)

17 **Skin Signs of Systemic Disease, Part II**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

18 **Thyroid Function Tests**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

18 **Diabetes**
2 p.m.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

18 **Endocrinology and Metabolism**
11 a.m.—Greystone Park Psychiatric

CME OPPORTUNITIES

Pages 766-771

THE MENOPAUSE WORKSHOP

Saturday, November 22, 1980
CMDNJ-Rutgers Medical School
Piscataway, New Jersey

This workshop will bring together a group of highly distinguished national and international researchers and clinicians. Interchanges between the faculty and the audience will expose controversies, clarify ambiguities, and lead towards a rational and balanced approach to the management of menopausal problems.

Inquiries: Pat Reid, CMDNJ-Continuing Education, Box 101, University Heights, Piscataway, NJ 08854 (201) 463 - 4707.

SECOND ANNUAL MINIRESIDENCY IN OCCUPATIONAL MEDICINE

COLLEGE OF MEDICINE AND DENTISTRY OF NEW JERSEY

DEPT. OF ENVIRONMENTAL AND COMMUNITY MEDICINE
RUTGERS MEDICAL SCHOOL
PISCATAWAY, NEW JERSEY 08854

PURPOSE:
To provide a background in Occupational Health. To aid in obtaining board eligibility and certification. To teach what was not taught in medical school. To bring you the latest advances. To provide continuing education, (90 hours credit in Class 1 for Physicians Recognition Award).

TIME:
From March 9 – March 27, 1981 / 15 weekdays daily from 8:30 – 4:30, 6 evening classes Tuesdays and Thursdays 6:30 – 8:30.

SUBJECTS:
Epidemiology and Statistics, Toxicology – Neurotoxicity, Industrial Hygiene, Occupational Diseases (Dermatology, Ophthalmology, Psychiatry), Infectious Diseases, Immunology, Hepatology – Nephrology, Public Health Administration, Medical Department Administration, Ergonomics, The Woman in the Workplace, Disability Evaluation – Stress Testing, Ionizing Radiation.

TUITION:
$975. for full course/$175. for any selected session of 2 days

FOR INFORMATION CONTACT:
J. Lieben, M.D. at above address or call

201-463-4772

Academy of Medicine of New Jersey
NJSDH—Genetics Services Program
CMDNJ—Rutgers Medical School
Hemophilia Association of New Jersey

Presents A Symposium On

HEMOSTATIC DISORDERS—PATHOPHYSIOLOGY AND MANAGEMENT

on
Saturday, November 8, 1980
at
CMDNJ—Rutgers Medical School
Piscataway, N.J.

The program will include presentations by nationally prominent speakers on the clotting mechanism, pathophysiology of hemostasis, Von Willenbrand's Disease, disorders of platelet function, anticoagulant therapy, thrombolytic therapy and current management of Hemophilia. The program is designed for internists, pediatricians, general practitioners and dentists as well as allied professionals working in the field.

For Further Information Contact:

Henrietta Golub
Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, N.J. 08648
Phone: (609) - 896-1717

EIGHTH SEMINAR AND WORKSHOP IN ACUPUNCTURE AND PAIN CONTROL

Sponsored by:

NEW YORK SOCIETY OF ACUPUNCTURE FOR PHYSICIANS & DENTISTS, INC.
AMERICAN COLLEGE OF ACUPUNCTURE, INC.
AMERICAN ACADEMY OF ACUPUNCTURE, INC.

Co-Sponsored by:

NEW YORK UNIVERSITY POST-GRADUATE MEDICAL SCHOOL
NEW YORK UNIVERSITY COLLEGE OF DENTISTRY

October 31, November 1, and 2, 1980
BARBIZON PLAZA HOTEL, NEW YORK CITY

Accreditation

As an organization accredited for continuing medical education, the New York University Post-Graduate Medical School certifies that this continuing medical education offering meets the criteria for 30 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Course Description

Chronic pain, including chronic facial pain, is among the most difficult of challenges to confront the practicing clinician. In the management of chronic pain, acupuncture is a most valuable tool when properly applied. This course, presented by authorities who have long been outstanding in the field, is designed to provide an update on the role of acupuncture in pain control, as well as in the clinical applications. Essential information and techniques will be presented for advanced as well as beginner students, and the course will include patient presentations and clinical instruction in the use of acupuncture. The course is approved by the New York State Boards for Medicine and Dentistry for 30 credit hours towards the State Acupuncture certification requirement. For further information and application write:

S.J. Yue, M.D., Secretary
New York Society of Acupuncture for Physicians and Dentists, Inc.
115 East 61st Street
New York, NY 10021

or call Sandy at (212) 870-6153
Mon. to Fri. 11 AM to 3 PM

Hospital
(AMNJ)

19 **Dermatological Conference**
6-8 p.m.—Rutgers Community Health Plan-U.S. Highway 1 and Rt. 18, New Brunswick
(CMDNJ-Rutgers Medical School)

20 **Appropriate Uses of Tranquilizers**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

21 **Pulmonary Diseases**
12 noon—Freehold Area Hospital
(AMNJ)

25 **Topic to be Announced**
7:30-9:30 p.m.—Coachman Inn, Cranford
(New Jersey Blood Club and AMNJ)

25 **Current Radiation Therapy**
8 a.m.—Princeton Medical Center
(AMNJ)

Dec.

1-2 **Advanced Cardiac Life Support Course**
6-7 9 a.m.-5 p.m.—NJ Medical School, Newark
(CMDNJ-NJ Medical School and AMNJ)

3 **Head and Neck Cancer**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

3 **Breast Cancer**
17 **Out-Patient Surgery**
9-11 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

3 **Cardiology Conferences**
17 3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick
(CMDNJ-Rutgers Medical School, Somerset County Heart Association and AMNJ)

3 **Monthly Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(AMNJ Endocrinology Section)

3 **Internal Medicine and Therapeutics**
10 9-11 a.m.—Roosevelt Hospital, Menlo
17 Park
(Middlesex General Hospital and AMNJ)

3 **Endocrine Conferences**
10 3:30-5 p.m.—Rotates between Newark
17 Beth Israel Medical Center, College Hospital, Newark, and VA Medical Center, East Orange
(AMNJ Endocrinology Section)

3 **Medical Grand Rounds**
10 11:30 a.m.-1 p.m.—VA Medical Center,
17 East Orange
(AMNJ Endocrinology Section)

3 **Transfusion Therapy and Blood Group Serology**
10 **Platelet Function and Dysfunction**
17 **Medical Treatment of Gallstones**
24 **Nutrition Throughout the Human Life Cycle**
31 9:30-11:30 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital & AMNJ)

4 **Immunology '81**
11 4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

4 **Medical Grand Rounds**
11 9:30-11 a.m.—Newark Beth Israel
18 Medical Center
(AMNJ Endocrinology Section)

5 **Renal Conferences in Nephrology**
19 2-3:15 p.m.—College Hospital, Newark
(Nephrology Society of NJ and AMNJ)

5 **Medical Grand Rounds**
12 11:30 a.m.-1 p.m.—College Hospital,
19 Newark
26 *(AMNJ Endocrinology Section)*

6 **General Otorhinolaryngology**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

6 **Infection in Renal Failure**
9 a.m.-5 p.m.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center and AMNJ)

9 **Arrythmia Management**
8-9:30 p.m.—Shore Memorial Hospital, Somers Point
(Shore Memorial Hospital and AMNJ)

9 **What's New in Cancer Chemotherapy?**
23 **Health Care Policy: Diagnosis/Prognosis**
12 noon-2 p.m.—West Jersey Hospital, Camden
(West Jersey Hospital)

10 **Diseases of the Pituitary**
1 p.m.—Christ Hospital, Jersey City
(AMNJ)

10 **Is Atherosclerosis Reversible?**
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(Dover General, Riverside and St. Clare's Hospitals and AMNJ)

10 **Medical Lecture Series**
17 1-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

11 **Nutrition Intervention Techniques**
5-6 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

11 **Gastric Emptying and Unexplained Dyspepsia**
8-9 p.m.—Rancocas Valley Hospital, Willingboro
(Burlington County Medical Society and AMNJ)

11 **Diseases of the Pituitary**
11:45 a.m.-1 p.m.—John F. Kennedy Medical Center, Edison
(AMNJ)

13 **The Coordinated/Uncoordinated Child**
8:30 a.m.-4:30 p.m.—NJ Medical School, Newark
(AMNJ)

15 **Clinical Cardiology**
7-8 p.m.—Paul Kimball Hospital, Lakewood
(Paul Kimball Hospital and AMNJ)

16 **Gastrointestinal Bleeding**
2 p.m.—St. Mary's Hospital, Orange
(AMNJ)

16 **Venereal Diseases: Diagnosis/Treatment**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

17 **Fibrotic Lung Diseases**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

17 **Alcohol Hepatitis and Its Complications**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

19 **Diabetes**
12 noon—Freehold Area Hospital
(AMNJ)

23 **Diabetes**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

23 **Adrenal Diseases**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

NEUROLOGY/PSYCHIATRY

Nov.

3 **Anorexia Nervosa in Adult Women**
8-10 p.m.—4 Garden Place, Nutley
(Essex Psychiatric Doctors' Seminars and AMNJ)

5 **Forensic Medicine**
19 **Community Psychiatry**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

5 **Diagnosis of Borderline Conditions**
12 **Munchhausen's Syndrome**
19 **Assertiveness Training**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

5 **New Therapies Through the Eyes of a Psychoanalyst**
8-10:30 p.m.—So. Orange Jr. High School
(Mental Health Assn. of Essex County, National Assn. of Social Workers, NJ, NJ Psychiatric Assn., NJ Psychological Assn., Dept. of Psychiatry, NJ Medical School, Society of Certified Clinical Specialists and Psychiatric Nurses, NJ State Nurses Assn. and AMNJ)

5 **Primary Physicians and the Female Patient**
9 a.m.-1 p.m.—St. Michael's Medical Center, Newark
(St. Michael's Medical Center and AMNJ)

5 **Clinical Use of the A.P.A. D.S.M. III**
9 a.m.-12 noon—Essex County Hospital Center, Cedar Grove
(Essex County Hospital Center and AMNJ)

6 **Group Therapy**
13 **Group Therapy**
20 **Case Presentation**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

6 **Case Reviews**
13 **Psychopharmacology and Compliance Issues**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

7 **Geriatric Psychiatry**
14 1:30-2:30 p.m.—Trenton Psychiatric
21 Hospital
(Trenton Psychiatric Hospital and AMNJ)

7 **Neuronatomy/Neuropathology and**
14 **Clinical Neurology**
21 4-5 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

7 **Forensic Psychiatry**
14 2:45-3:45 p.m.—Trenton Psychiatric
21 Hospital
(Trenton Psychiatric Hospital and AMNJ)

19 **Sleep-Wake Disorders**
9:30-11 a.m.—Bergen Pines County

The Basic Science Section of the
COLLEGE OF PHYSICIANS OF PHILADELPHIA

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THE KIDNEY: BASIC SCIENCE AND CLINICAL PRACTICES

FRIDAY, NOVEMBER 21, 1980
to be presented by:

Michael W. Weiner, M.D.
Assistant Professor of Medicine
Stanford University School of Medicine
Palo Alto, California

Robert Narins, M.D.
Professor of Medicine
Temple University School of Medicine
Philadelphia, Pennsylvania

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For further information contact Mrs. Dagny Henderson, College of Physicians of Philadelphia, 19 South 22nd St., Philadelphia, PA 19103, (215) 561-6050, Ext. 31 or 48.

AMERICAN FOUNDATION FOR THE PREVENTION OF VENEREAL DISEASE

announces the following AMA approved course:

SEXUALLY TRANSMITTED DISEASES IN WOMEN AND CHILDREN

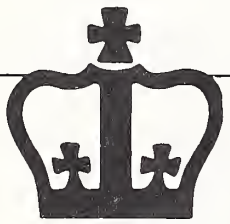
Sunday — Fee: $50. (includes lunch)
November 16, 1980 — 9 a.m.-5 p.m.
Course Direcetor:
Yehudi M. Felman, M.D., F.A.C.P.
Director, Bureau of VD Control
New York City Health Department

This one day course is designed for physicians in private practice, interns, residents and public health professionals.

Topics will include Chlamydial Infections, Gonorrhea and Pelvic Inflammatory Disease in Children and Child Abuse, Gonorrhea in Adolescents, Genital Herpes and Vaginal Infections.

The course is accredited by the New York City Health Department for Category 1 CME credit (seven hours towards the American Medical Association's Physician Recognition Awards).

For information, write or phone **Francis J. Santora, VD Education Unit, New York City Health Department, 93 Worth Street, New York, N.Y. 10013; 212/925-4036.**



THE COLLEGE OF PHYSICIANS & SURGEONS, COLUMBIA UNIVERSITY

Postgraduate medicine courses for *September* through *November:*

Advances in Surgical Pathology, Oct. 6-8, 1980. Fee: $300 (or $125 per day); resident's fee: $150 (or $60 per day) includes syllabus and luncheons. (24 credit hours). Cecilia Fenoglio M.D. and Luciano Ozzello, M.D.

Symposium On The Optic Nerve, Oct. 9 and 10, 1980. 11th Annual Course of Edward S. Harkness Eye Institute. Fee: $200 (resident's fee: $100) includes luncheons. (14 credit hours). Myles M. Behrens, M.D.

20th Annual Review Course In Obstetrics and Gynecology, Oct. 20-24, 1980, Fee: $375 (resident's fee: $200), includes luncheons and syllabus. 37 credit hours, Category 1, A.M.A.'s P.R.A.; 35 Cognates, A.C.O.G.; 33 1/2 credits, A.A.F.P. Raymond Vande Wiele, M.D.

Basic Medical Hypnosis, Oct. 27-30, 1980. *Fee: $400 (resident's fee: $300). (32 credit hours). Herbert Spiegel, M.D., Barbara DeBetz, M.D., David Spiegel, M.D.

Hypnosis and Psychiatry, March 23-26, 1981. *Fee: $400 (resident's fee: $300). (32 credit hours). Herbert Spiegel, M.D., Barbara DeBetz, M.D., David Spiegel, M.D. *If **Hypnosis and Psychiatry** and **Basic Medical Hypnosis** are registered for at the same time, the combined fee is $700 (resident's fee: $550).

Postgraduate Review Course of Procedures Used In The Practice of Allergy, Nov. 5-7, 1980, at the New York Academy of Medicine. Cosponsored by the American Academy of Allergy, R.A. Cooke Institute of Allergy of St. Luke's-Roosevelt Hospital Center. Fee: $250 (resident's fee: $125) includes luncheons. (22 credit hours). Michael Grieco, M.D., William Kniker, M.D.

Postgraduate Review Course in Neuroanatomy, Neurophysiology, and Neuropharmacology, Nov. 13, 1980—April 4, 1981 (20 Sats., 9:30-Noon), Fee: $420 (resident's fee: $210). (42 credit hours). Edgar M. Housepian, M.D.

Eye Disease Recognition Management for All Physicians, Sat., Dec. 6, 1980, includes luncheon. Fee: $85 (resident's fee: $20). (7 credit hours). Robert M. Day, M.D.

Names of Course Directors follow each listing. All courses are approved for Category 1 credit of the A.M.A.'s Physician's Recognition Award. Contact: DR. ELIZABETH C. GERST, Director, Continuing Education Center, College of Physicians & Surgeons, 630 West 168th Street, New York, N.Y. 10032; telephone: (212) 694-3682.

Hospital
(Bergen Pines County Hospital and AMNJ)

19 **Update on Psychotropic Medications**
1:30 p.m.—Trenton Psychiatric Hospital
(AMNJ)

19 **New Strategies in Affective Illness Treatment**
2:30-4:30 p.m.—Fair Oaks Hospital, Summit
(Fair Oaks Hospital)

19 **Sex Education Course**
1:30-3 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)

20 **Drinking Patterns of Adolescents**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

Dec.

1 **Stuttering Following Incest**
8-10 p.m.—192 Chittenden Rd., Clifton
(Essex Psychiatric Doctors' Seminars and AMNJ)

3 **Epidemiology of Epilepsy**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

3 **Psychosocial Stresses in Human Life Cycle**
10 **Short-term Psychodynamic Psychotherapy**
17 **Organic Brain Syndrome**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

4 **Diagnosis and Treatment of Chronic Pain**
11 **Hypnosis Update**
18 **Sex and Communication between Couples**
12 noon-1:30 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

4 **Sleep Disorders in DSM III and Other**
11 **Current Sleep Developments**
18 11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

9 **Psychotropic Medication**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

10 **Movement Disorders: Update**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

15 **Headache**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

17 **Mental Patients in the Street**
8-10 p.m.—Mayfair Farms, West Orange
(Tri-County Chapter of the NJ Psychiatric Association and AMNJ)

OBSTETRICS/GYNECOLOGY

Nov.

5 **In Vitro Fertilization and Embryo Transfer in Animals**
6-7 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)

5 **Microsurgery in Treatment of Infertility**
8-10 p.m.—Clairidge House #2, Apt. 12, Verona
(NJ Medical Women's Association Journal Club and AMNJ)

15 **Obstetrics/Gynecology Seminar**
7:30 a.m.-2 p.m.—West Jersey Hospital, Camden
(West Jersey Hospital)

Dec.

3 **Distinguished Lectures in Obstetrics/Gynecology**
6-7 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)

PATHOLOGY

Nov.

12 **Clinical Pathology Conference**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

19 **Forensic Pathology**
9 a.m.-5 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

22 **Annual Fall Slide Seminar**
9 a.m.-1 p.m.—Rutgers Medical School, Piscataway
(NJ Society of Pathologists and AMNJ)

Dec.

13 **Pathology Workshop**
9 a.m.-4 p.m.—Medical Society of NJ Executive Offices, Lawrenceville
(NJ Society of Pathologists and AMNJ)

PEDIATRICS

Nov.

6 **Pediatric Malabsorption Syndrome**
9 a.m.—Freehold Area Hospital
(AMNJ)

15 **Pediatric Plastic Surgery**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

21 **Diagnostic Bronchoscopy in Children**
7:45-9:15 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

Dec.

4 **Thyroid Disorders in Children**
9 a.m.—Freehold Area Hospital
(AMNJ)

19 **Pediatric Pharmacology/Therapeutics**
7:45-9:15 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

RADIOLOGY

Nov.

12 **Case Presentations**
7:45-10:15 p.m.—Morristown Memorial Hospital
(Radiological Society of NJ and AMNJ)

13 **Visiting Professorship Program**
1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston
(St. Barnabas Medical Center)

19 **Dinner Meeting**
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

20 **Topic to be Announced**
8 p.m.—Hospital Center at Orange
(Radiological Society of NJ and AMNJ)

GENERAL SURGERY

Nov.

1 **Surgical Infection**
8 a.m.-1 p.m.—New Jersey Medical School, Newark
(Merck Sharp & Dohme and AMNJ)

4 **Tumor Conferences**
11 12 noon-1 p.m.—Morristown Memorial
18 Hospital
25 *(Morristown Memorial Hospital and AMNJ)*

20 **Breast Reconstruction**
7:30-9 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

Dec.

2 **Tumor Conferences**
9 12 noon-1 p.m.—Morristown Memorial
16 Hospital
23 *(Morristown Memorial Hospital and*
30 *AMNJ)*

3 **Case Presentation**
10 **Surgical Therapy in Occlusive Cerebrovascular Disease**
17 **Case Presentation**
24 11:30-12:30 p.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

13 **Annual Meeting**
Resorts International Hotel, Atlantic City
(New Jersey Chapter, American College of Surgeons)

18 **Septic Shock**
7:30-9 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastic, and Vascular Surgery.)

Nov.

12 **Indications for Carotid Surgery**
6:30-10:30 p.m.—The Manor, West Orange
(Vascular Society and AMNJ)

19 **Cancer of the Bladder**
26 **Advances in Orthopedics**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(Columbus Hospital and AMNJ)

25 **Proficiency in Microsurgery**
8-10 p.m.—Englewood Club, Palisade Ave., Englewood
(Englewood Surgical Society and AMNJ)

26 **Vascular Disorders of the Intestines**
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(Dover General, Riverside and St. Clare's Hospitals and AMNJ)

Dec.

13 **General Ophthalmology**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

16 **Arthroscopy of the Knee**
8-10 p.m.—Englewood Club
(Englewood Surgical Society and AMNJ)

18 **Spinal Cord Injury Service Quarterly Meetings**
1-2:30 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

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LETTER TO THE JOURNAL

Glucagon Program

August 17, 1980

Dear Dr. Krosnick:

As you know I am very much a supporter of your "Glucagon in School" program. However, as I commented to you *via* the telephone, I feel we may have gotten the cart in front of the horse. There are numerous instances of insulin-dependent diabetic youngsters who are visiting the school nurse unnecessarily for "insulin reaction." Indeed, I have a youngster who averages three visits weekly—always before his mathematics class! He presents none of the signs or symptoms of hypoglycemia, but is nonetheless kept in the nurse's office, loaded with rapidly absorbed carbohydrates, and so on. The fact is he is "using" the system—and to everyone's disadvantage (most notably his). We have documented his pattern by insisting on several occasions that he be sent directly here for blood glucose, and never have found the level anywhere near approximating "shock."

The thrust of what I want to suggest is that we really should be sure the school nurses can document hypoglycemia *before* giving glucagon. This, obviously, will take—I think—legislative backing in order to permit them to do instant blood glucoses *via* Chemstrip®, Dextrostix®, or whatever the particular local preference may be.

(signed) Robert H. Areson, M.D.

OBITUARIES

Dr. Herbert A. Baron

Word has been received of the death on February 22 of Herbert A. Baron, M.D., of Hasbrouck Heights, a member of our Bergen County component. A native of Brooklyn, born in 1911, Doctor Baron received his medical degree from the University of Berne in Switzerland in 1935 and returned to the United States for internship and residencies. He established a general practice in Hasbrouck Heights which he maintained until his death. Dr. Baron was affiliated with Paterson General and Hackensack Hospitals. He was active in civic affairs and had been police and fire surgeon in his community.

Dr. Wilmer F. Burns

Wilmer F. Burns, M.D., a member of our Camden County component, died on June 3 in Cooper Medical Center following complications as a result of a fractured skull. A native of New Jersey, Dr. Burns earned his medical degree from the University of Pennsylvania School of Medicine in 1934 and was a family practitioner in Audubon for many years. He had been on the staff at Cooper Medical Center and was active in community affairs, having been president of the board of health of Audubon and medical inspector for the school district. During World War II Dr. Burns served with the medical department of the AUS. He was 70 years old at the time of his death.

Dr. Salvatore Caridi

At the grand age of 88, Salvatore Caridi, M.D., a member of our Hudson County component, died at his home after a long illness. A native of Italy, Dr. Caridi was graduated from the University of Naples School of Medicine in 1917. He emigrated to the United States in the early 1920s and located in Hudson County to practice family medicine, retiring in 1973. Dr. Caridi had been affiliated with the North Hudson Hospital in Weehawken and was a member of the Academy of Medicine of New Jersey. In 1967 he was a recipient of MSNJ's Golden Merit Award, indicating fifty years of medical practice.

Dr. Francis P. Carrigan

Word just has been received that Francis P. Carrigan, M.D., one of Essex County's senior members, formerly of Newark, died on August 13, 1979. Born in Vermont in 1898, Dr. Carrigan was graduated from Columbia University College of Physicians and Surgeons in 1926 and pursued a career in radiology, becoming board certified in that specialty. He was a Fellow of the American

College of Radiology and had been affiliated with St. Michael's Medical Center in Newark, St. James Hospital there, and St. Mary's Hospital in Orange. During World War II, Dr. Carrigan served in the medical department of the AUS. He received MSNJ's Golden Merit Award in 1976 marking his fiftieth anniversary as a practicing physician.

Dr. C. Walter Carroll

One of Mercer County's renowned physicians, C. Walter Carroll, M.D., of Trenton died on August 16 in Morris Hall Rehabilitation Center. A native of Trenton, Dr. Carroll was graduated from Georgetown University School of Medicine in 1927 and pursued graduate studies in surgery at New York University and Polyclinic Hospital in New York. He joined the surgical staff at St. rancis Medical Center in Trenton ultimately attaining the rank of chief of surgery. He also served that institution for several terms as president of the medical staff. Dr. Carroll was active in civic affairs and during his career had been physician for the City of Trenton and for Mercer County and police and fire surgeon. He was a Fellow of the International College of Surgeons and of the American Society of Abdominal Surgeons. Dr. Carroll, who was 79 years old at the time of his death, had been a recipient of MSNJ's Golden Merit Award in 1977 marking fifty years devoted to the practice of medicine.

Dr. Sidney H. Carsley

Sidney H. Carsley, M.D., a member of our Union County component, died on August 14. A native of Massachusetts, Dr. Carsley was graduated from the University of Vermont School of Medicine in 1936 and pursued a career in the practice of allergy and dermatology. He had been affiliated with the Muhlenberg Hospital in Plainfield where he maintained his office. He was a Fellow of the American College of Allergy. During World War II, Dr. Carsley served with the medical department of the AUS. He was 69 years old at the time of his death.

Dr. Sidney P. Cohen

Sidney P. Cohen, M.D., a member of our Essex County component, died on August 1 at his home in Deerfield Beach, Florida, where he was living in retirement. A native of New York City, born in 1904, Dr. Cohen was graduated from New York University Medical College in 1931. He practiced general medicine with special interest in obstetrics in Nutley until retirement in 1975. He had been affiliated with Presbyterian Hospital in Newark, East Orange General, St. Mary's Hospital in Passaic, and Margaret Hague Maternity Hospital in Jersey City. During World War II Dr. Cohen served with the medical department of the AUS.

Dr. Hilda C. Fliegel

A member of our Hudson County component, formerly of Jersey City and now retired to Coral Springs, Florida, Hilda C. Fliegel, M.D., died on July 23 at University Hospital there. A native of New York City, Dr. Fliegel was graduated from Women's Medical College in Philadelphia (now Pennsylvania Medical College) in 1931 and practiced in Hudson County until moving to Florida in 1978. She had been affiliated with Christ Hospital in Jersey City and was also on the staff at New York City Infirmary.

Dr. Anthony L. Gricco

On August 18, Anthony L. Gricco, M.D., a member of the Cumberland County Medical Society, died at his home. Born in 1906, Dr. Gricco earned his medical degree from Jefferson Medical College, class of 1934, and practiced general medicine and surgery in Vineland for many years. He had been aa member of the surgical staff at Newcomb Hospital in Vineland.

Dr. Francis M. Karney

On August 6, Francis M. Karney, M.D., a member of our Union County component, died at his summer home in West Swanton, Vermont. Born in Fall River, Massachusetts, Dr. Karney earned his medical degree from Stefan Batory University in Wilno, Poland in 1935, and came to Garwood as a family practitioner in 1941, where he remained until retirement. He had been affiliated with Alexian Brothers and St. Elizabeth's Hospitals in Elizabeth and with Rahway Memorial Hospital. Dr. Karney was 82 years old at the time of his death.

Dr. Harold A. Kazmann

Harold A. Kazmann, M.D., formerly of Asbury Park, died on July 15 at Sequoia Hospital, Redwood City, California, following brain surgery. Born in Russia in 1895, Dr. Kazmann came to the United States as a child and received his medical degree from the University of Illinois in 1919. He took a residency in surgery in New York City, followed by further graduate studies in abdominal surgery at the Royal Academy in Budapest, Hungary, returning to New Jersey in 1933 to establish a practice in general surgery. Dr. Kazmann was a Fellow of the American College of Surgeons and had been director of the surgical department at Monmouth Medical Center and chief of surgery at Fitkin Hospital (now Jersey Shore Medical Center). In 1958 Dr. Kazmann retired from private practice and moved to Los Gatos, California, and accepted a position as the American College of Surgeons' representative in the western one-third of the United States. He had served a term as president of his county medical society (Monmouth) and was active on numerous committees and boards of various service organizations including the World Health Organization and the board of trustees of the New Jersey chapter of the American Cancer Society. Dr. Kazmann was the author of several articles in the medical field and had been active in organizing the San Francisco chapter of the American Medical Writers' Association of which he was president in 1962. During World War II Dr. Kazmann served with the medical department of the United States Navy in the Pacific theater.

Dr. Nathan Miller

Nathan Miller, M.D., a former member of our Essex County component, now retired, died in Monmouth Medical Center, Long Branch, on June 27 after a long illness. A native of Newark, born in 1906, Dr. Miller was graduated from George Washington University School of Medicine in 1933 and pursued a career in obstetrics and gynecology. He was a Fellow of the American College of Obstetricians and Gynecologists and a member of its New Jersey component, and a member of the Academy of Medicine of New Jersey. He had been affiliated with St. Michael's Medical Center in Newark. Dr. Miller had been living in Long Branch.

BOOK REVIEWS

Psychic-Nexus: Psychic Phenomena in Psychiatry and Everyday Life

Berthold Eric Schwarz, M.D. New York, Van Nostrand/Reinhold, 1980. Pp 308. Illustrated. ($14.95)

The author is a well-known New Jersey psychiatrist who has been a student of psychic phenomena for many years. Besides telepathy, clairvoyance, telekinesis and precognition he includes levitation, bilocation, astral traveling, teleportations, healings, stigmatisms, materializations, dematerializations, spirit photographs, direct voice and paranormal audiotape voices as subjects of a psychic nature which he considers very suitable for psychiatric analysis. Over the past twenty years Dr. Schwarz has written about many of these topics and about possibly related phenomena such as the ordeals by serpents, fire and strychnine of the Holiness sect of eastern Kentucky, and close encounters with unidentified flying objects.

In this work he has rewritten earlier publications and presented new material on his data and theories about these controversial areas. His chapter on the ordeals of members of the Holiness sect who appear to be safe from fire, rattlesnakes, copperheads and toxic doses of strychnine while in states of religious exaltation is impressive; if reasearch of a more controlled nature is possible, much may be learned of importance to psychophysiology and psychosomatic medicine. His many anecdotes claiming to provide evidence of telepathy and precognition probably will not convince the skeptic.

Dr. Schwarz believes that unconscious resistance to probing the unknown prevents most people from being aware of telepathic and other psychic phenomena which go on in everyday life. This certainly may be a reason why we appear either to believe or disbelieve accounts of such phenomena rather than considering the evidence rationally. Dr. Schwarz states the psi is not a question of belief or unbelief, but one of fact collecting, collation, critical study, analysis and undertanding. His book presents the current state of study and analysis; however, if you are not already a believer you are unlikely to be converted by reading it.

A. Arthur Sugerman, M.D.

Structure and Function of the Circulation, Vol. 1

C.J. Schwartz, N.T. Werthessen, S. Wolf, eds. New York, Plenum Press, 1980. Pp 819. Illustrated. ($75).

Over the years I've learned to look askance at textbooks that are compilations of articles by assorted authors; they usually are disjointed and redundant, and present a disturbing admixture of prose. Dr. Schwartz and his colleagues, however, have succeeded in avoiding these problems. This text, designed to be the first volume of a projected three volume set, has in one reading assuaged my initial prejudice. Great care has been taken, obviously, to avoid the pitfalls of compilations, and there is a consistent format throughout the chapters.

The emphasis in Volume I is on basic research and scientific knowledge outside of clinical vascular disease. There is an index which, while not exhaustive, is adequate for the researcher.

The material in this text may at first seem intimidating to those not especially interested in the structure and function of the circulation, but in truth almost any reader will find much meat in this marvelous compendium. Although few clinical problems are discussed in this volume (Strandness' discussion of collateral circulation is the exception), there are many sections of the book that will be of interest to the practitioner. For example, in the chapter by Harris on the "Arteries in Greco-Roman Medicine," one finds a fascinating exposition of ancient attitudes and views on the human circulation. Similarly, though I find little practical value in the lengthy section on the functional morphology of arteries, or the blood supply of nerves, these subjects are presented in such an easy reading fashion that browsing through them proved a worthwhile and enjoyable experience. The one defect of a collected series that persists is the unevenness in the length and depth of chapters. While 12 chapters are presented in approximately 800 pages, the single chapter on the functional morphology of arteries consumes 290 pages of the text. There is an amazing amount of information in this section, and I was astounded at the material that is available in what was to me a relatively mysterious topic. Nevertheless, only the serious researcher will make full use of this information.

The book contains treatises on arterial embryology, visceral circulation, circulation of the extremities, regulation of arterial flow, vascular anatomy, hormonal control and physiology of the renal circulation, and the interesting juxtaposition of "Innervation of Arteries" and "Blood Supply to Nerves." The two chapters on renal circulation and physiology were particularly edifying with a fine exposition of control mechanisms and an elegant discourse on a variety of complex subjects.

We await future volumes with great anticipation, and hope for sections on veins, lymphatics, the blood supply to the myocardium, and other material that obviously is missing from this volume.

I would recommend this book to anyone interested in cardiovascular diseases, not only as a reference volume for obscure material (there are excellent reference lists at the end of each chapter), but also as a source of enjoyable reading for the more casual student. I would not be without it.

Victor Parsonnet, M.D.

Cesarean Childbirth: A Handbook for Parents

C. C. Wilson and W. R. Hovey. New York, Doubleday/Dolphin. Pp. 297. Illustrated. ($6.95 Paperback)

This book represents yet another log thrown upon the fire of "consumerism" that is engulfing the medical profession as well as practically every other profession today. Fortunately for physicians this particular contribution to consumers' understanding of obstetrics, anesthesiology and pediatrics in general, with particular emphasis upon cesarean delivery, is well written by two apparently mature authors who are not crusading to undermine patient-physician relations entirely.

There is an orderly progression through antepartum care, cesarean delivery, and postpartum situations including potential complications. The authors recognize the consumers' expectations of, if not demand for, perfection and provide the type of sound advice and guidance that hitherto might have been accepted from doctors, parents, and/or clergymen before the overintellectualized, psychological approach achieved popularity.

The book is recommended highly for obstetrical nurses, for patients who already have experienced one cesarean section, and for patients whose history suggests the probability of a cesarean section. In those areas of the country where the cesarean rate is still close to the traditional ten percent, this book might create needless anxiety for the primigravida. Where the cesarean rate is close to twenty percent, this book might be very instructive to patients as well as obstetricians, however the latter would probably be disinclined to recommend it to the former.

Since the fire of consumerism already has been ignited and has been receiving daily fuel from journalists, authors and lawyers, physicians are obliged to learn to live with it and hope that a better-educated patient clientele will read with discernment, accepting the mature contributors and rejecting the sensationalists. Even *Cesarean Childbirth* has some sentences that a few physicians might find objectionable from the standpoint of patient interference with obstetrical and/or pediatric judgment, but taken in its entirety the book covers a wide range of subjects that physicians have been studying and practicing for years and explains them in relatively simple terms.

Jerome Abrams, M.D.

Clinical Methods in Pediatric Diagnosis

Balu H. Athreya, M.D., New York. Van Nostrand/Reinbold, 1980. Pp. 289. Illustrated. ($24.50).

Read Dr. Athreya's delightful new contribution to the literature of pediatric diagnosis; it will nourish your enthusiasm and also teach you many fascinating things about the examination of the child.

The style of the writing is conversational. It is almost as if you were sitting on the porch in a rocker discussing the fascinating minutiae of physical diagnosis. Except for a few misspellings, a few grammatical misconstructions, and several poor photographs the text is clear and easy to read. I am certain these problems will be corrected in the next edition.

Have you ever thought to ask an anxious patient "What do you wish this is not?"? It sounds like it is worth trying. See page 37 for a good picture of an infant with the sensory deprivation syndrome. Would you like to know more about palpebral fissures, clubbing, thumbs, dermatoglyphics, and much more?

Even though Dr. Athreya writes in his preface that this book is intended for medical students and house officers, I suggest that many "grandfather types" practicing pediatrics and family medicine will enjoy and benefit from reading this book.

Solomon J. Cohen, M.D.

Review of Medical Microbiology, 14th ed.

E. Jawetz, J.L. Melnick, E.A. Adelberg. Los Altos, CA, Lange, 1980. Pp 593. Illustrated. ($14)

Review of Medical Microbiology is my favorite book of the five Lange Medical Series. Jawetz, Melnick and Adelberg are the finest group of comprehensive microbiologists in the world today. Melnick's chapters on virology are the most concise and readable chapters on this subject of any textbook. This accurate up-to-date presentation of medical microbiology now is published in Spanish, German, Italian, Turkish, Portuguese, Serbo-Croatian, French, Polish, Japanese and Albanian, attesting to its popularity.

Although the book is directed to students and the practicing doctor, I believe that it is most useful to infectious disease specialists, to review update areas, other than our own. For example, the changing terminology of bacteriology and the rapid development of genetics and oncogenic viruses are new and exciting fields, even to clinicians. The reviews could be stronger in parasitology and chemotherapy, which are not the forte of the authors.

Overall a great review book and superbly written for rapid information.

Leon G. Smith, M.D

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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(203) 661-9702

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11. Advertisers' Index:
No.

12. Services to Advertisers:
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13. Staff
Editor: Arthur Krosnick, M.D.; Managing Editor: Marjorie D. Treptow; Executive Director: Vincent A. Maressa.

14. Circulation:
All members of the Medical Society of New Jersey.

15. Guaranteed Circulation:
All members of the Medical Society of New Jersey.

16. Circulation Verification:
Publisher's statement, postal receipt verification.

17. Rates Per Thousand:
Based on the 12-times rate of $330 and circulation of 10,000: $33.00.

The JOURNAL of the Medical Society of New Jersey

Rate Card effective January 1981

18. Coverage and Market

a. Coverage: All member of the Medical Society of New Jersey, plus trade circulation.

b.

GP	2,790
IM	1,597
GS	1,222
OBG	693
PED	582
DERM	170
ALL	68
UROL	181
OTO	368
PSYCH	547
OPH	322
CARD	78
GASTRO	28
ANES	234
TOTAL	9,687

c. Trade Circulation:
Non-member physicians
Medical libraries
Medical schools
Drug manufacturers
Medical book publishers
Medical abstract services
Advertisers
Advertising agencies
Subscriptions
Total approximately 650

d. Readership Survey: A readership survey by Health Industries Research shows that the JOURNAL is extremely well read. Copies are available upon request.

19. MEMBERSHIP CIRCULATION BY COUNTIES OF STATE OF NEW JERSEY

Atlantic	24
Bergen	1,13
Burlington	27
Camden	56
Cape May	5
Cumberland	14
Essex	1,77
Gloucester	11
Hudson	56
Hunterdon	7
Mercer	57
Middlesex	59
Monmouth	54
Morris	51
Ocean	27
Passaic	73
Salem	5
Somerset	18
Sussex	7
Union	85
Warren	6
Total	9,40

Guaranteed Circulation: 10,000

The JOURNAL of the Medical Society of New Jersey Rate Card effective January 1981

ates

). Issuance:
a. Frequency: Monthly
b. Issue Date: 10th of month
c. Mailing Date: 10th of month.

. Closing Dates for Space:
a. Reservations: 1st of month preceding month of sue
b. Cancellations: 6th of month preceding month of sue

. Agency Commission:
15%

. Cash Discount:
2%, 10 days.

. Rates:

	1 time	3 times	6 times	12 times
page	370	360	350	330
2 page	190	180	175	165
4 page	95	90	88	86
8 page	60	55	50	45

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Earned Rates:
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. List of standard colors: AAAA standard red, en, blue, yellow, orange.
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. 3-color rate: $410 plus earned black and white e.
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The JOURNAL of the Medical Society of New Jersey Rate Card effective January 1981

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THE JOURNAL is printed by offset.
Trim size: 8 x 11

31. Plate Sizes:

Page Unit	Dimensions
1 full page	7 x 10
1/2 horizontal	7 x 4-7/8
1/2 vertical	3-3/8 x 10
1/4 vertical	3-3/8x 4-7/8
1/8 vertical	3-3/8 x 2-3/8

32. Bleed Sizes:

Page Unit	Dimensions
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1/2 vertical	11-1/4 x 4-1/16

33. Insert Requirements:
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Quantity—11,500

34. Paper Stock:
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35. Type of Binding:
Perfect bound.

36. Halftone Screen:
Up to 133 screen.

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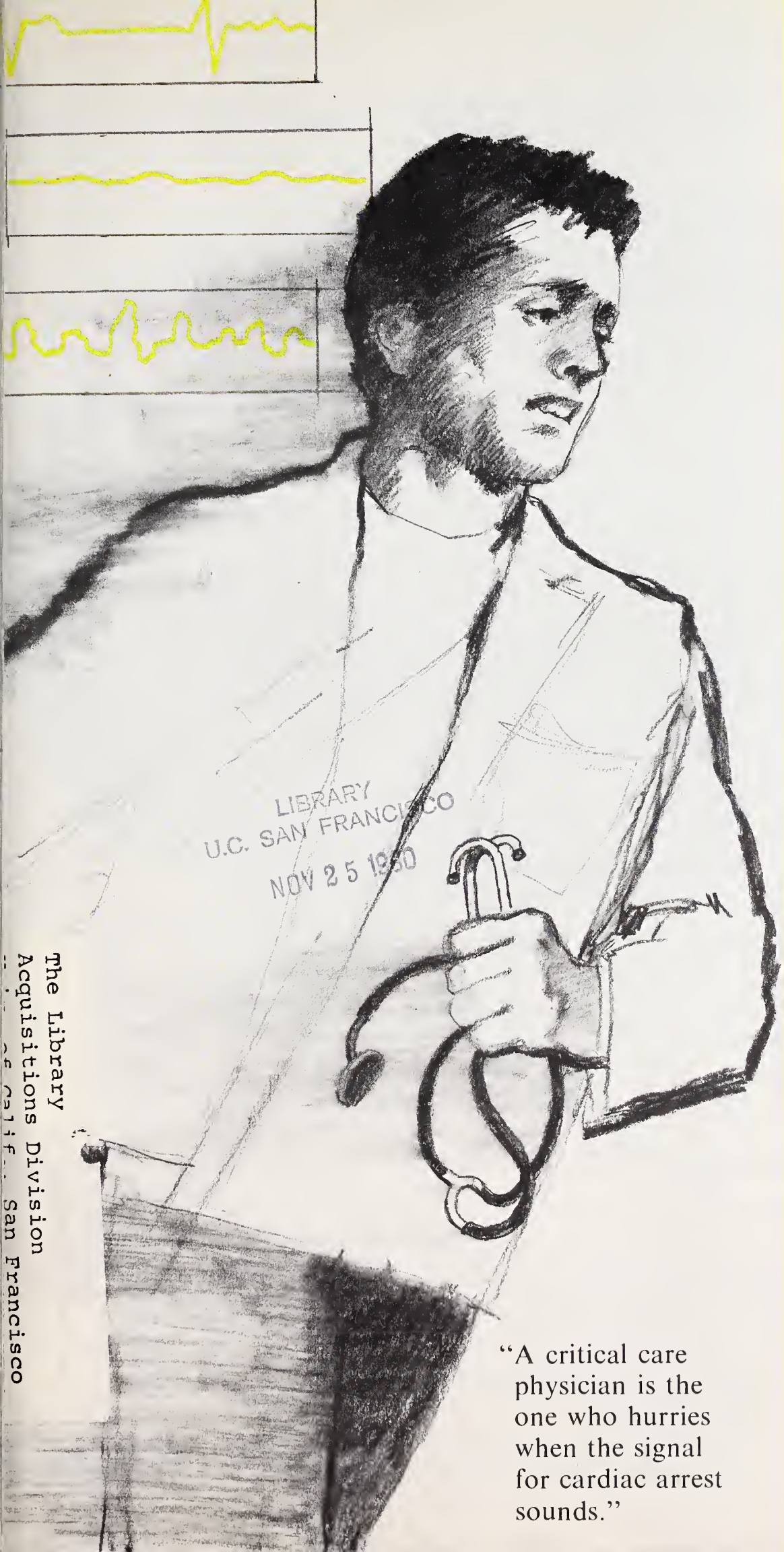

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B. A. Waisbren, M.D.

Office Abortion
P. S. Green, M.D.

Delay in Hospitalization for Myocardial Infarction
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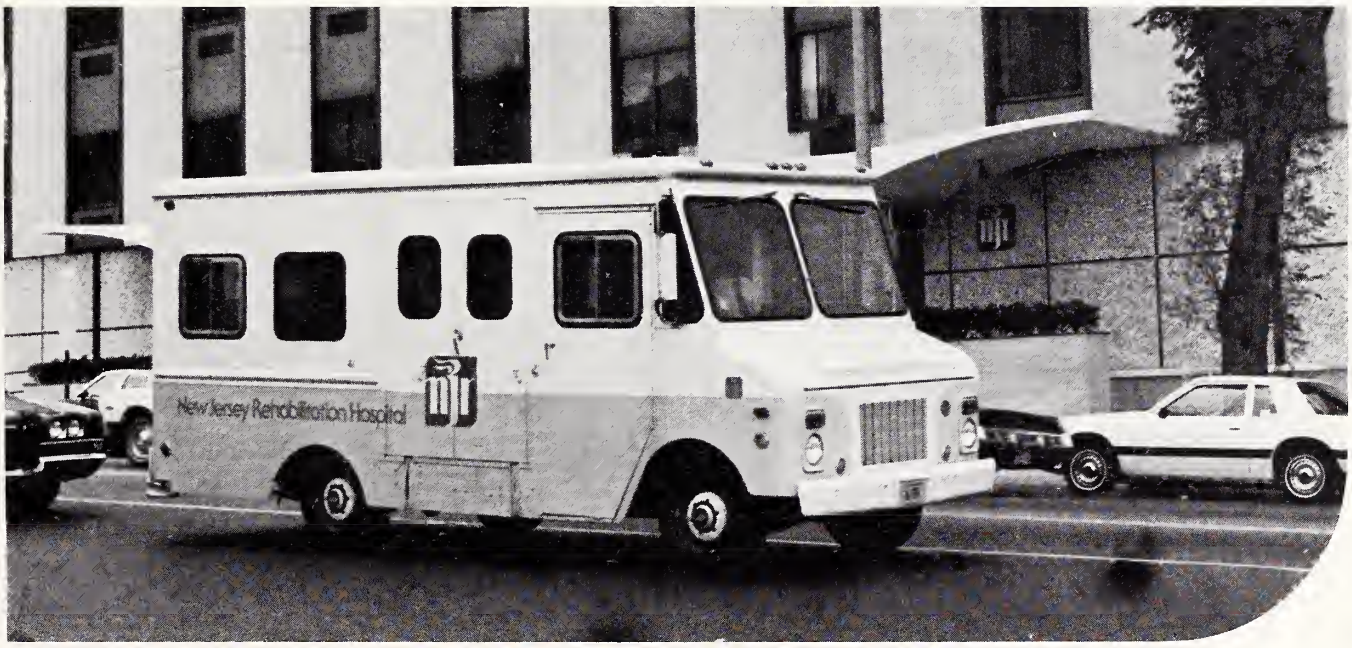

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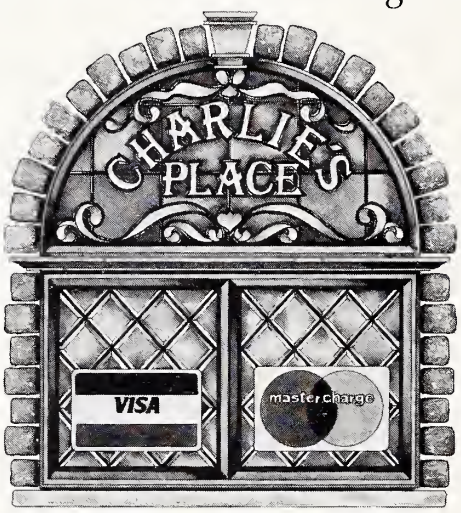

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Featuring: Arizona Medical Association Survey on Attitudes Toward Malpractice Suits

ARIZONA MEDICAL ASSOCIATION STRESSES COMMUNICATION SKILLS

A recent survey conducted by the Arizona Medical Association tends to give credence to assumptive comments espoused by those involved in the matters of malpractice. The survey was designed to examine the opinions, attitudes, and behavior of consumers and physicians toward physician services, especially as they may have an impact on malpractice suits. It was conducted during a two-month period in mid 1979, via telephone questionnaire administered to 1,000 consumers and via mailed survey to 1,000 physicians, 591 of whom responded.

Table #1 exhibits some of the general overall attitudes of consumers and physicians toward health practices.

Consumers continue to have an essentially positive image of physicians, particularly if the patient has remained with the same physician over a period of time.

Interestingly, both groups agree that physicians do a poor job of explaining medical problems to patients. The survey strongly suggests the need for physicians to stress and develop skills in interpersonal communication. One thought expressed by both groups as an aid to better communications is the publication of brochures concerned with common health problems. These brochures should be developed and provided by physicians and given directly to the patients.

Opinions regarding factors which contribute to malpractice produced some rather interesting commonality, as illustrated in Table #2.

In addition to the opinions documented in the table a substantial segment, as indicated in Table #3, though a minority, were willing to instigate a suit if they had been seriously wronged.

The study further was able to produce the following profile of those who most likely would sue physicians:

. . . 18-34 years of age
. . . live in metropolitan area
. . . a good education
. . . middle or upper income level
. . . male
. . . have children at home
. . . a relatively frequent visitor to a doctor

The results of this survey give substance to the premise that better education of the consumer and better communications between education of the consumer and better

Table 1 †
Consumer Attitudes Toward Physicians and Health Practices Compared with Physician Perceptions of Consumer Attitudes Toward the Same

Statement	Attitude** Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
a. Most doctors (the public feels that most physicians) are ethical and responsible people.	49.5 (36.0)	39.8 (54.9)	4.4 (5.3)	4.2 (3.3)	2.1 (0.5)
b. In most malpractice suits, the doctor is not at fault (The public feels that physicians are not at fault in most malpractice suits)	9.9 (3.1)	22.0 (28.9)	42.8 (24.8)	18.1 (35.5)	7.2 (7.4)
c. Doctors (the public feels that physicians) charge too much for the services they provide.	40.3 (27.5)	22.6 (56.8)	13.7 (9.1)	14.0 (4.5)	9.5 (1.4)
d. Most doctors (the public feels that physicians) are more interested in making money than the well-being of their patients.	11.9 (2.2)	19.3 (9.6)	14.2 (9.1)	29.3 (36.0)	25.4 (42.9)
e. In general, doctors (the public feels that physicians) do a poor job of explaining medical problems to patients.	27.6 (19.3)	22.9 (57.3)	8.9 (13.3)	25.3 (8.6)	15.4 (1.6)

** The physicians' results (expressed in parentheses) represent their perceptions of how the public views physicians and health care.

†Reprinted from the *Consumer and Physician Attitudes Toward Physician Services, Medical Malpractice and Patient.* Arizona Medical Association, Inc. 1979.

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

Table 2 †

Consumer and Physician Opinions Regarding Factors Contributing to the Malpractice Insurance Crisis

Question: What do you think has caused the cost of malpractice insurance to be so high?

Factors Mentioned	Percent of Respondents Mentioning* Consumers	Physicians
Doctors themselves at fault	19.5	21.7
Lawyers at fault	13.7	52.8
Court/judicial system at fault	16.6	31.0
Insurance companies at fault	2.8	15.2
Number and dollar amounts of suits being filed	44.2	38.2
Greediness of patients	32.8	23.2
High expectations of patients (expect a lot from doctors)	–	11.4
Other	1.3	28.7

Question: In your opinion, why do patients sue doctors?

Factors Mentioned	Percent of Respondents Mentioning* Consumers	Physicians
Greedy people bringing unwarranted suits	50.7	41.5
Doctors making mistakes	45.3	59.7
Greedy lawyers encouraging suits	14.5	22.7
Publicity associated with big settlements	7.1	4.7
Juries/judges awarding big settlements	4.6	–
Inflation, cost of medical care, etc.	3.5	7.9
Anger, frustration, etc.	–	28.2
Other	5.0	33.6

*Columns sum to over 100 percent because of multiple responses to the question.

Table 3 †

Likelihood of Suing if You Developed a Serious Medical Problem and Doctor Might Be at Fault

Likelihood of Suing	Percent of Total*
Very likely	11.9
Somewhat likely	18.4
Undecided	29.6
Somewhat unlikely	17.6
Very unlikely	22.6

Likelihood of Suing if Spouse or Parent Died and Doctor Might be at Fault

Likelihood of Suing	Percent of Total
Very likely	17.3
Somewhat likely	22.2
Undecided	29.6
Somewhat unlikely	13.8
Very unlikely	17.1

*Columns sum to over 100 percent because of multiple responses to the question.

communications between the physician and patients can produce the positive effect of decreasing professional liability claims.

The survey also revealed public support for various legislative proposals related to the malpractice problem. Of those surveyed, two-thirds endorsed the following three suggestions:

(1) A law requiring that all disputes between physicians and patients be submitted to a panel of expert physicians and lawyers for arbitration.

(2) A law limiting the percent of settlement that lawyers could receive.

(3) A law requiring that a malpractice claim be reviewed by a panel of expert physicians and lawyers before going to court.

The Arizona Medical Association should be commended for seeing the need for such a survey and publishing the results. Surveys of this nature enlighten the readership and give credence to previously perceived premises. However, the underlying purpose of this type of study is to induce a behavioral change in those surveyed. In this light, the Arizona Medical Association report clearly indicates the need for physicians to develop good physician/patient communicative skills which will enhance their professional image and act as a deterrent to professional liability claims.

ALTERNATIVES TO THE COUNTERSUIT

Judith Graves Higgs, J.D. writing in the August 1980 issue of *Specialty Law Digest: Health Care* explores the topic of physicians' countersuits as a solution to the malpractice dilemma.

Ms. Higgs states that while countersuits may provide some relief for the wrongfully sued physician, "the preferred course would be to preclude suits." She recommends that physicians be more attentive to the following as "precluders" of claims:

(1) non-medical causes of malpractice actions, i.e., advising patients of any prolonged absence and providing substitute medical care; discussing fees with an aim toward reaching an amicable understanding;

(2) careful and thorough forewarning of potential risks to patients;

(3) assurance that consent is understood by the patient and willingly given;

(4) attention to patients' fears and worries;

(5) attention to record keeping and the taking of medical histories;

(6) elimination of unguarded comments about physicians' work.

(7) more attention to "patient-physician relationships"

In her concluding paragraph Ms. Higgs strongly advocates the pursuit of a major underlying meaning behind such mechanisms as New Jersey's *Rule 4:21* Panel Hearings and the Medical Inter-Insurance Exchange of New Jersey's peer review panels as well as MIIENJ's working relationship with the New Jersey Chapter, Association of Trial Lawyers of America.

"The solution to the malpractice dilemma may well lie with the interrelationship of the two professions (Medical and Law) directly involved. The members of these professions seem intent on casting themselves in adversarial roles, which only serves to compound and to aggravate the malpractice problem. No form of countersuit will be quite as effective or satisfactory a relief as that which might be achieved by cooperation and communication between the physician and the attorney."

PARENTS FAIL TO PROVE LACK OF INFORMED CONSENT TO SURGERY FOR BRAIN TUMOR

A child's parents failed to prove lack of informed consent to an operation to remove a brain tumor, an Indiana appellate court ruled.

The child underwent an operation in 1965 when she was two years old to remove a tumor from her cerebellum. Not all of the tumor was removed by the surgery or subsequent cobalt treatments. Nevertheless, she progressed well and after eight years had only minor impairments.

In September 1973 she was taken to a neurosurgeon for an examination; tests confirmed that the tumor had recurred. Surgery was performed and the tumor was redrained, since it was too large for removal. During the closing of the skull the patient's heart stopped. She was resuscitated within 20 to 45 seconds, but never recovered consciousness and remained comatose at the time of trial four years later. In a malpractice suit based on the physician's alleged failure to inform the patient's parents of the risks involved in the operation, trial court directed a verdict in favor of the physician.

Affirming the decision, the appellate court said that expert medical testimony was required to establish a case under the informed consent theory. The physician testified that the patient's reaction during the operation was an extremely rare occurrence. No other medical expert testified at trial. The court said that the physician could not be held liable for failure to disclose a risk that he did not know and had no duty to know.

The parents testified that they would not have undergone treatment had they known of the risk and that they would have chosen another physician. The court said that there was no proximate cause and affirmed the decision. . . . Revord v. Rusell, 401 N.E. 2d 763 (Ind. Ct. of App., March 26, 1980) *The Citation,* Vol. 41, No. 7, July 15, 1980.

DID YOU KNOW

. . . A concept of prepaid legal insurance is being considered within the legal profession. The plan would permit individuals and groups to purchase insurance to pay for legal fees, just as "Blue Shield" covers physician fees as part of prepaid medical insurance.

. . . "According to a recent California Supreme Court decision physicians who fail to explain dangerous consequences when patients decline suggested diagnostic tests, can be liable in a wrongful death claim." (*Malpractice Lifeline,* August 22, 1980)

. . . "Insurance experts note that a sagging economy historically brings increases in both the number of suits filed and the size of awards. But this time around, you probably won't be alone in the malpractice arena. Architects, real estate agents, accountants, even insurance salesmen, are scrambling to purchase coverage—spending about $1.5 billion a year. Medical malpractice coverage still accounts for the bulk of liability premiums paid, though, at about $3.3 billion annually." *Medical Economics,* August 4, 1980.

SPECIAL NOTICE

An excellent booklet, entitled *Amniocentesis for Prenatal Chromosomal Diagnosis,* has been prepared by the Center for Disease Control, for prospective parents who may present a higher-than-normal risk of having a child with birth defects. Copies may be requested through this Department at MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

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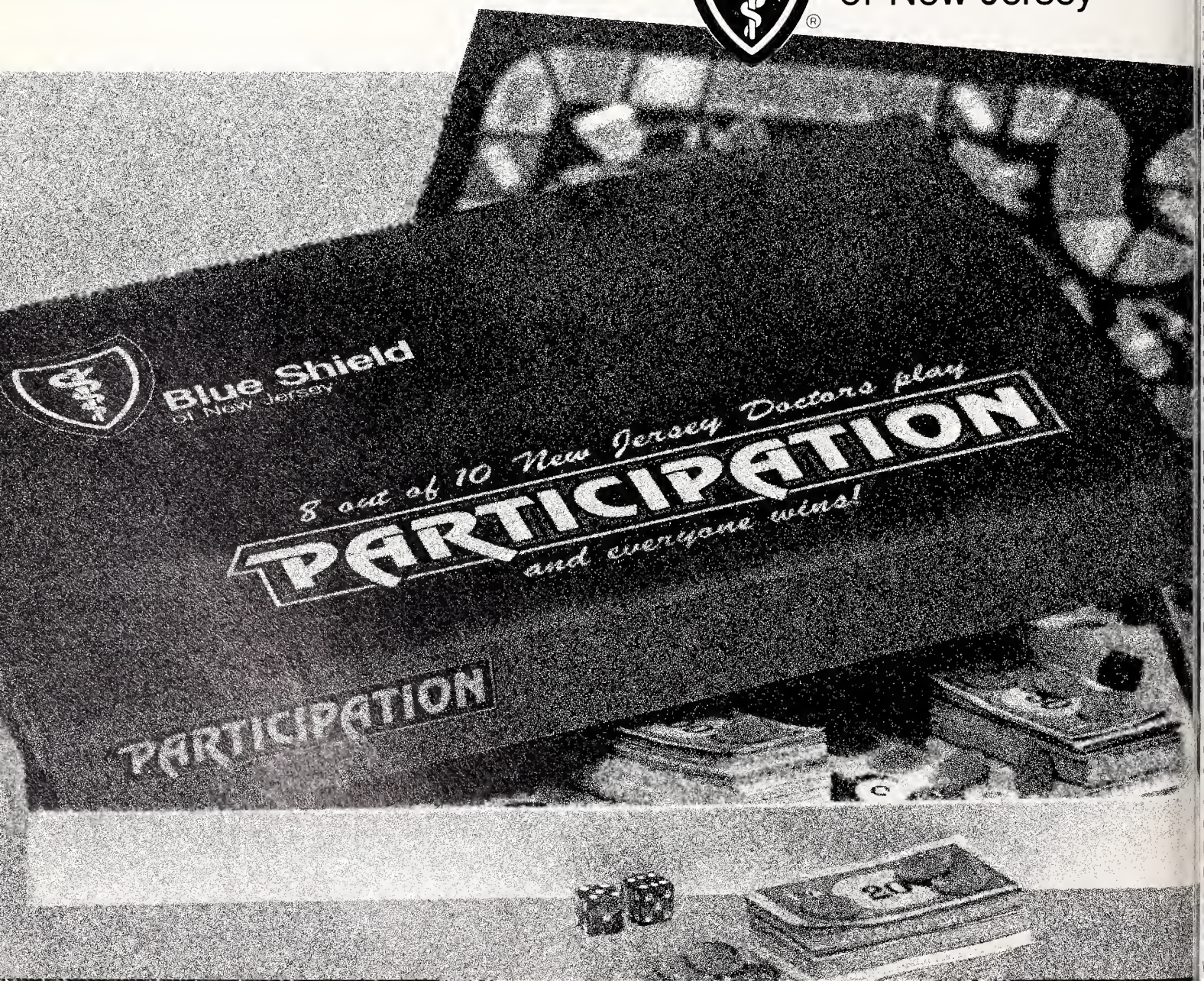

EDITORIALS

Foreign Medical Graduates and the AMA

At a time when American Medicine needs strength through consolidation of ideological, intellectual, influential and financial resources, it does not appear to be getting the quantity or quality of participation needed from the large number of foreign medical graduates (FMGs) who entered the United States in the last two decades.

Intern and resident training programs—particularly in New Jersey—were a major attraction to FMGs, many of whom remained here to practice, raise families and to become integrated into American life. A considerable number of such physicians married American women while most brought their wives (and children, if any) from their native land. They have prospered medically and financially. Some have attained professorial rank on medical school faculties and, at the community and hospital level, they have had full opportunity to become hospital medical staff officers, department heads, and community leaders.

But, for some reason, FMGs have failed to join the American Medical Association in any substantial numbers. According to Lanjewar, in January 1978, there were 87,000 foreign medical graduates in the United States.[1] Of that group, 74,000 were licensed to practice medicine in at least one state, but only "somewhat more than one-third are members of the American Medical Association."[1] This author, who suspected that FMGs "would be expected to be well disposed toward joining the ranks of organized medicine," believes that failure to join the AMA is because FMGs "have not been approached and recruited."

One of the problems may be competing organizations. At present, a New Jersey physician's professional loyalty is demanded by a number of coalitions—his hospital staff, specialty society, the university on whose faculty he may hold an appointment, a specialty "college" (ACS, ACP, and others), the Academy of Medicine, the county component medical society, the State Medical Society. At the same time, there are a number of international medical confederations (International College of Surgeons, International Diabetes Federation, and so on) which bid for his membership.

One of the latter organizations is the American College of International Physicians (ACIP), which was organized in 1975 "as a non-profit participating fellowship for physicians educated in medical schools abroad and in the United States, who are licensed and practicing in the United States." Among its purposes are: "(1) to shape policies for the future of medicine in the United States and around the world in the fields of medical education, research, ethics, and international health activities; (2) to help to create a climate conducive to the development of the full potential of all international physicians now practicing in the American continent; and (3) to help to formulate the national interest in international health activities because of the unique internationality of its fellowship and its expertise in the health needs of countries abroad."[2]

The ACIP is attempting to expand its membership but claims that it is encouraging FMGs to become active in organized medicine—presumably through membership in the AMA. These appear to be laudatory aims, but it appears to this editor that United States Medicine needs a strong central medical organization with the clout of the AMA and not dozens of special interest medical organizations of Lilliputian dimensions with lofty ideals which they never can fulfill in a meaningful way. There are no "international physicians now practicing in the American continent." Such individuals, if they emigrated to the United States, became citizens and gained licensure, are "American physicians," who were born and educated in other countries but who have voluntarily chosen to make this country their home and their place to study, to perform research and to practice medicine. This phenomenon started in the eighteenth century—not in the 1950s—and characterizes hundreds, perhaps thousands, of men and women, who have become renowned in the annals of American medicine.

FMGs should, indeed, be "approached and recruited" to join the AMA. As American physicians, they should enter the mainstream and work and fight for the survival of freedom for all practitioners in this country. They should not be detoured into some hypothetical concern for the practice of medicine in international locales when there are monumental threats from outside forces in their adopted land which take aim at American Medicine daily. FMGs owe this to United States Medicine just as much as American medical graduates (AMGs) do.

Foreign medical graduates are urged to join the AMA, the Medical Society of New Jersey and its county components. They should identify with organized medicine, seek committee appointments, gain House of Delegate seats. They should raise issues of concern to all—at reference committee meetings, board of trustees' meetings, and all other forums of medical interest.

FMGs, join organized American Medicine—join the AMA! A.K.

[1]Lanjewar DG: Guest editorial. *NY J Med* June 1980.

[2]American College of International Physicians, Inc. News Release. Fort Wayne, Indiana, August 4, 1980.

State Medical Specialty Societies—What Role?

The New Jersey medical specialty societies are playing an increasingly important role in medical affairs. Their areas of interest include: continuing medical education, problems of ethics, problems of fee complaints often referred by county medical societies, as well as relationships with other medical organizations, including national specialty societies, the Medical Society of New Jersey and the Academy of Medicine of New Jersey. In their efforts, these organizations have not supplanted other medical organizations, but rather have supplemented, and assisted programs in effect.

FUNCTIONS

In continuing medical education, the state specialty society holds a unique position in its ability to formulate educational programs for members. These societies are aware of the educational needs and desires of their members, know which of these needs can be fulfilled on a local level, and understand their members' preferences as to how best to fill these needs.

These organizations have been active in the field of "ethics." Such issues frequently are referred to the specialty societies by the county medical societies, and by the Medical Society of New Jersey. Although issues of ethics, physician competence, and fee disputes relate to physicians in all specialties, some of the questions that arise require specific knowledge of a particular specialty.

Legislative and political activity, for most specialty societies, implies working through larger organizations. The specialty society is generally not large enough to have an effective voice in government. It must therefore try to present its views in larger organizations, most often the State Medical Society. Of course, the Medical Society of New Jersey must represent the combined interest of all members, and will not necessarily be able to represent the interests of a particular group, at any given time. On the other hand, when a unified course is decided upon, the specialty society has been most successful in mobilizing the support and efforts of members, and can provide real assistance for MSNJ in this fashion.

One of the most important functions of any medical specialty society is as intermediary between its members and other medical organizations. The intermediary function works both ways. Not only should the specialty society be able to represent to such organizations as MSNJ the interests of its members, but it also must be prepared to present to its members the issues and problems before MSNJ or the AMA. This function is vital to both sides.

The New Jersey Association of Medical Specialty Societies (NJAMSS) has been conceived as a forum for the officers of the various specialty societies to meet and to discuss problems on an ongoing basis. There has been concern that this new orgnaization is somehow in conflict with or in opposition to MSNJ. It is not!

NJAMSS

The primary purpose of NJAMSS is to assist the individual specialty societies in those functions they already perform. These functions are frequently in the interest of MSNJ, or are requested by it (CME programs of MSNJ annual meeting, participation in peer review panels, and others).

Similary, NJAMSS will not "fragment" the physicians of New Jersey, for its forums have demonstrated that we all face similar problems and that one group's problems today will be another group's tomorrow. For the solutions to these problems, for unified action, the Medical Society of New Jersey is, and will remain, the effective organization for us all.

By action of the House of Delegates, the Board of Trustees was authorized to petition the New Jersey Legislature to amend MSNJ's corporate charter to recognize the right of the Society to define the representation in its House of Delegates. If this is accomplished further action by the House will permit the inclusion of specialty society representatives in the House.

Each Society's vote, though it may have little impact on the actions of the House, will be an important symbol of participation in New Jersey's organized medicine. It is unlikely that such specialty society delegates will form a unified voting block because of the specialties they represent and, indeed, they may be in conflict on some issues.

Introduction and identification of the voices of New Jersey's specialty societies, which are very active and influential medical subcultures, will further strengthen the Medical Society of New Jersey.

Paul J. Hirsch, M.D.

Cost Containment—Be Wary!

The burgeoning preoccupation of the medical community with cost containment has introduced a number of questionable and fearful elements which are creating a startling impact on long-accepted principles of health care. The heavy tread of the boot of broad federal regulation has, in its effort to enforce curtailment of health care expense, extended beyond reasonable limits in eradicating what it perceives to be unacceptable extravagance. There has developed an almost irrepressible compulsion to restrain widespread usage of the most progressive of technological achievements which have brought diagnosis to its highest pinnacle. An example in point refers to the incredibly stringent restrictions on the purchase by hospitals of CAT scanners.

Physicians widely agree that the CAT scanner is one of the most valuable diagnostic tools ever invented. By sliding a patient into the interior of this big machine, they can get an immediate and comprehensive view of the condition of vital organs, including the brain. It is common knowledge that the scanner and modifications thereof probably will be the most important and the most indispensible radiographic modality of the eighties. Although doctors have been clamoring for scanners as the equipment has improved and its uses have

broadened, hospital medical staffs are no longer free to make such acquisition decisions on their own. Their capital acquitions are controlled by the federal health planning act, as administered by state and local health planning and health systems agencies. To purchase a CAT scanner, it is necessary to obtain a "certificate of need" (CON) from such an agency and the request may be turned down. Scanners cost up to $750,000 and rejecting a request for one allows bureaucrats to pretend to be doing something about the cost of medical care.

The Wall Street Journal relates that faced with bureaucratic red tape, some groups of doctors have banded together to buy CAT scanners on their own. They often have had to locate them off hospital premises to bypass the regulations. Hence, the expression, coined by health planning bureaucrats, "fugitive scanners."[1]

In concert with this awesome development, orthodox criteria of established clinical behavior now are being challenged. While no expense is spared in creating the most sophisticated military instruments of destruction, the newest life-saving modalities are in peril of being withheld.

It generally is recognized that governmental agencies (e.g., Federal Trade Commission and Federal Aviation Board) invariably have failed miserably both as to cost containment and efficiency, so there is little hope that as complex a system as health care could be managed more efficiently by regulatory authority.

A study of hospital regulation by Sloan and Steinwald[2] using American Hospital Association data on 1,228 hospitals, found that "as a group, regulatory programs did not do much to contain hospital costs during the first half of the 1970s." In addition to certificate-of-need regulation, the authors studied the effects of revenue limitations and utilization review. Their findings indicated that hospitals' accelerated cost increases, in anticipation of new regulations and comprehensive regulatory programs, had essentially no impact on hospital costs. Indeed the long-run effect on hospital expenses was almost twice its previous amount. Nor could they find strong effects from prospective reimbursement programs or utilization review.[3]

In a consideration of prevention and cost containment Mervyn Susser has concluded that preventive programs will not lower the costs of medical care.[4] Doctor Elizabeth A. Goessel states that it is not possible for the PSRO to effect cost-containment.[5]

During the past decade some 60-odd federal and state regulatory bodies have come to bear on the operation of health care facilities, burdening both hospitals and taxpayers with regulatory costs and inhibiting advances in the use of modern medical technology. In Passaic county, among the seven community hospitals which service the area, there is not a single scanner.

Do American citizens really want to curtail their chances of life and good health by such restrictive constraints on the availability of life-saving devices? It is likely that the populace which demands military security, also desires the ultimate in health care and will approve the additional expenditure for what it is worth.

It is within the scope of this context that the value of excretory urography prior to prostatectomy has been questioned in urological circles. To assess objectively the influence and necessity of such preoperative survey, regarded hitherto as inextricable with prostatic surgery, a study undertaken by Pinck *et al.* concluded that the intravenous pyelogram still is required as part of the urologic evaluation.[6]

The impact of cost-containment actions has not necessarily rebounded to the benefit of patients. It should be the policy of organized medicine to accept the necessity to contain costs to eliminate excess and extravagance and to reduce hospitalization where feasible. However, unquestioned acceptance without critical evaluation of many proposed aspects of cost-containment might result in poor treatment.

Informed physicians should adopt an attitude which is at once cooperative and concerned, but at the same time wary and circumspect about economic matters which threaten acceptable standards of good medicine.

Bernard D. Pinck, M.D.

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New Jersey Medical Political Action Committee JEMPAC

JEMPAC REPORTORIAL

A UNITED FRONT

JEMPAC continuously encourages MSNJ members to express to elected officials their opinions on legislation which will have an impact on their private and professional lives. Legislation which will have an impact upon the entire membership is brought before the MSNJ's Council on Legislation for review, comment, and opinion. Members of MSNJ have a right, and in fact are encouraged, to make their views known to the Council in writing, through their county society, medical specialty society, or by personally addressing the Council.

The position recommended by the Council on Legislation and approved by the Board of Trustees regarding proposed legislation serves as the official position of MSNJ. This information is printed in *The Journal,* in the Informational Bulletin of the Council on Legislation and in its annual report which is presented to the House of Delegates.

Once MSNJ has adopted an official stand on proposed legislation, it is most important that physicians present a united front. A physician writing to an elected official opposing the stand taken by MSNJ only can weaken MSNJ's position. Physicians who are opposed to the position adopted by MSNJ on a particular bill should write to the Board of Trustees or the Council on Legislation and express the opposing view, requesting reconsideration of the official stand.

AMPAC/JEMPAC CONTRIBUTES TO CAMPAIGNS

The Candidate Evaluation Committee chaired by Harold Colburn, M.D., opted to make $19,950 in AMPAC/JEMPAC contributions to New Jersey candidates for election to the 1980 House of Representatives. Following its usual non-partisan stance, AMPAC/JEMPAC aided eight Democratic candidates and seven Republican candidates in their pursuit of a House seat.

In addition to the financial assistance, JEMPAC launched a "Get Out the Vote" campaign in conjunction with the American Medical Association's "I'll Be There" campaign. Registration regulations along with voter reminders were mailed to all members of MSNJ and the Auxiliary. A brochure prepared by the New Jersey Department of State entitled "Your Ticket To Power" which contained a voter registration form was part of the mass mailing. JEMPAC also ran a full-page advertisement in the October issue of *The Journal* entitled "Vote, It May Be Worth the Bother," as an additional reminder to MSNJ members to vote in the November election.

1981 AMPAC/JEMPAC ACTIVE MEMBERSHIP CONTRIBUTION INCREASE

In 1981 AMPAC will celebrate its 20th Anniversary. Although much has changed in those 20 years, one thing has remained the same—the AMPAC contribution. Since AMPAC's inception in 1961 the contribution for an active membership has been $10. In contrast, however, the cost of campaigning has increased over 100 percent in the same period.

For AMPAC/JEMPAC to continue effectively to support candidates for Federal and State office an increase in contributions for active membership is necessary. Contributions for sustaining membership will remain the same.

The following table indicates the increase in the 1981 contributions:

	1980		
	AMPAC	JEMPAC	Total
Active	$10	$25	$35
Spouse	10	5	15
Sustaining	50	50	100

	1981		
	AMPAC	JEMPAC	Total
Active	$20	$30	$50
Spouse	20	5	25
Sustaining	50	50	100

MSNJ'S POSITION ON PROPOSED NJ LEGISLATION

Senate-299-Charles B. Yates (7th District, part of Burlington)

To require all hospital and medical expense insurance policies issued to individuals, other than group subscribers, to include benefits for vitamin supplements when prescribed by a physician. **ACTIVE OPPOSITION** because the treatment is unscientific and because existing regulations permit reimbursement under general medical treatment. Assigned to **Institutions, Health and Welfare Committee:** Anthony Scardino, Chairman, William J. Hamilton, Vice-Chairman, Anthony E. Russo, Garrett Hagedorn, James P. Vreeland.

Assembly-744-Alan J. Karcher (19th District, part of Middlesex)

To make mandatory the revocation of a license to practice medicine if the licensee has violated any narcotic drug law. **ACTIVE OPPOSITION** because many violations are technical in nature and do not warrant revocation of a license, but a lesser penalty. Current law allows the State Board of Medical Examiners to impose a suspension or revocation according to the gravity of the offense and is preferable to this bill. Assigned to **Judiciary, Law, Public Safety and Defense Committee:** Martin A. Herman, Chairman, William J. Bate, Vice-Chairman, John Paul Doyle, Eugene J. Thompson, William E. Dowd, William L. Gormley, Walter M.D. Kern, Jr.

We urge you to write to the sponsors, the committee and committee members to make MSNJ's views known—c/o the State House, Trenton, NJ 08628.

*Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

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Realities of Critical Care Medicine—Present and Future

BURTON A. WAISBREN, M.D., Milwaukee, Wisconsin

In this overview of critical care medicine the type of patients who should be in a critical care unit, the physicians who should be involved, and the critical care units of the future are discussed. Emphasis is on *what* is done for the patient rather than *who* does it or *where* it is done.

In this overview of the realities of critical care will be presented what I think, not what I know, about the subject. I will share with you my educated guesses as to what the future might hold and what the current problems are. Let us start by looking at the delivery of critical care as a paradigm and examine some of its elements.

CRITICALLY ILL PATIENTS AND THE ENVIRONMENT

First, the type of patients in the system must be defined: A critically ill patient is one who has a potentially reversible condition, in which moment-by-moment decisions might be particularly beneficial in changing the course of his disease. A dying patient is past being critically ill. Critically ill patients include those with a ruptured viscus, broken intestinal anastamosis, overwhelming sepsis, acute renal shutdown, cardiogenic shock, shocked lung, severe burns, multiple trauma, recent open-heart surgery, recent surgery for morbid obesity, and many more. All of these patients have life-threatening conditions and should be in a critical care area, treated with a predetermined system of monitoring and contingency orders based on the results of this monitoring. An integral part of a system of critical care is the physical environment in which it is provided. When a new intensive care unit (ICU) or cardiac care unit (CCU) is designed, the physicians involved will have to assert themselves from the onset of planning to be sure of windows that allow patients and staff to see the sun, the daylight, and the night. It is no accident that architects put the critically ill "in the closet," an environment which so many units resemble. It is because of their awe of death. From the beginning, the physician will have to fight for the right of his most severely ill patients to battle for life in a place where they can see the sun, the earth, and the clouds. This is the time to prevent ICU psychoses, a problem with which we all have had to deal.

The physician also must see to it that undue isolation is not practiced in the critical care unit. The infections being dealt with in the critical care area are, for the most part in the abdominal cavity, the bloodstream, the chest, or the urinary tract. Such infections are not spread by air. Therefore, it should be a rare patient who requires bacterial isolation. The patients who do need protective isolation, however, are those with organ transplants and severe bone marrow depression; for them, the adequately equipped critical care unit will have a laminar flow room. The St. Mary's Hospital Burn Center, where I practice most of my critical care, is a large burn center managed without isolation. We challenge all other burn centers in the world to show that their isolation practices make a difference in their mortality or morbidity

*Presented at the First Annual Scientific Session of the New Jersey Society of Critical Care Medicine, Rutgers Medical School, October 10, 1979. Dr. Waisbren is Associate Director of St. Mary's Hospital Burn Center, Milwaukee, Wisconsin and Director of the Clinical Cell Biology Laboratory at the same institution. Correspondence may be addressed to him there, 2323 North Lake Drive, Box 503, Milwaukee, WI 53201.

> **"A critical care physician is the one who hurries . . . toward the patient when the . . . signal for cardiac arrest sounds."**

statistics. Isolation all too often means isolation from good care; it should be used only when its potential damage to the patient is weighed against its value.

THE CRITICAL CARE PHYSICIAN

After the patient, the next most important part of a critical care system is the patient's physician. The physician's feelings and rights and modus operandi are secondary to the patient's rights and feelings, but systems that function well must have a heart, a center, and a control panel. This function must be that of the patient's physician.

What is a critical care physician? There are many pathways by which a physician can become capable of taking care of critically ill patients, but the identification of a critical care physician is simple. A critical care physician is the one who hurries immediately toward the patient when the inhospital signal for a cardiac arrest sounds. The others are those who pretend not to hear or who dawdle, hoping someone else will get there first.

How much time should the critical care physician spend on the critical care unit? Very little, because with proper monitoring and staffing there are few critically ill patients who need a physician in constant attendance. A careful examination and analysis three or four times a day is almost always sufficient and a physician who is there more than that is apt to get in the way of the nurses, laboratory technicians, loved ones, physicians on teaching rounds, social workers, and respiratory therapists—all of whom need time with and for the patient.

What should the physician be doing the rest of the long, long day? He should be teaching all individuals he can everything he knows—nurses, students, residents, and other physicians. He should be teaching physicians how and when to use respirators, dialysis machines, balloon pumps, plasmapheresis, pulmonary artery catheters, and as much basic information regarding immunology, shock, clotting and lung physiology as he can cram into his own head. Whether he should be doing research is an individual matter. Research comes from the heart and not the head, and those who do it have a compulsion for it and those who are not really interested should not become involved. Whether a critical care physician is doing research or not, he had better be studying all he can. Today's research rapidly becomes tomorrow's treatment, so all physicians involved in critical care now should be getting ready to treat sick cells intelligently with such modalities as cyclic AMP, to administer plasmapheresis to a large group of patients who run the whole gamut of immune complex diseases, and to treat intractable heart failure with pump assists to be placed in or out of thorax. Organ transplants of pancreas, liver and bone marrow, with all their attendant problems, and installation of practical lung oxygenators also soon will be in their province.

The next consideration in a critical care unit is the proper place and function of house staff and medical students. They should look but not touch. It is a supreme irony that the majority of seriously ill patients in some of our finest medical centers are being treated by house staff with varying degrees of supervision. I have been there, so I cannot accept the canard that while the house staff writes the orders, the senior resident (and how extensive is his experience?) and the professor really are taking care of the patient. The man who writes the orders is taking care of the patient and all too often it is a senior medical student or resident thinking to himself, "Gee whiz, this is something" rather than thinking about what is happening to the cell membrane metabolism or the level of the capillary osmotic pressure. Some argue that resident physicians and students cannot learn unless they do, I merely say it can be done; *how* would have to be the subject of another lecture entitled "Medical Education in the Future."

Our present patients and their third-party payers are becoming aware of who actually is treating critically ill patients. They soon will be demanding, in the first case, that their own physicians take care of them, while the insurance carrier will pay only the doctors who write the orders. This point probably will be most unpopular, but I believe it is correct and make no apology for emphasizing to all physicians who are taking the responsibility for critically ill patients that to do so to the best of their ability they must write the orders themselves. To do less, in my opinion, is an abrogation of responsiblity and failure to live up to the patient's trust. Teaching of house staff is secondary to the patient's needs.

NURSES AND CONTINGENCY ORDERS

The next consideration is the nurse's role in critical care. Put simply, the nurse should be the physician's assistant. Having run an active burn center for 19 years without house staff, I greatly appreciate the superb professional nurses who respect and practice nursing. Our nurses at the St. Mary's Burn Center have come to realize that one of their functions is to do what the physician says with alacrity and enthusiasm. Although the nurse's facial expression may indicate what she thinks of the physician's orders, at crucial points she should not express an opinion unless it is asked for. This, of course, often should be done. By the same token, physicians should not interfere with professional nursing functions. This sensitive point must be considered in the context of the entire picture of critical care. Each physician taking care of critically ill patients must make it clear who is in complete charge of the patient, or, as nursing educators get more confident and more aggressive, the time may come when each unit's physicians will have to hire physicians' assistants instead of nurses. This will happen (and, in fact, has happened in some burn centers and cardiac centers) unless all concerned know and are willing to follow enthusiastically a chain of command that starts with the physician in charge.

I have expressed the opinion that physicians should not remain in the unit all day and then said that physicians should guard jealously their ultimate responsibility for the patient's specific care. This can and should be done by the simple expedient of *contingency orders*. These can be defined as orders to do something when and if something else happens. When in our community, contingency orders became a code word for "he wants to treat his own patients and does not trust the interns" (which is true), all sorts of reactions appeared. However, by the change of the words to

"providing parameters," the same concept is being accepted very well now. Another ploy to get contingency orders in force is to call them "conventions," a word that does not seem as inflammatory.

Four contingency orders that I have found most helpful should illustrate this concept. It should be noted that several of these orders assume that there is a catheter in the pulmonary artery and the point should be made here that this and a good arterial line are essential in critical care. If I had to pick the single most important mistake in critical care, I would choose overloading the patient with fluid. To some, "he is volume depleted" is the only remark they can make when confronted with a dying patient. The pulmonary artery pressure not only tells you whether or not this is true, but also tells you how much fluid you can give safely. The "gimmick" that allows pulmonary artery readings on all critically ill patients is the balloon catheter inserted through a subclavian line. This is done by placing a simple subclavian catheter, slipping a vein dilator over the line and inserting the double-port Swan Ganz catheter with the thermodilution tip. By this technique, the physician will know the cardiac output, the peripheral resistance, the extent of hydration, and many other useful parameters.[1] Anyone who can place a subclavian catheter can put in a Swan Ganz catheter; if even a few who read this start doing this through the subclavian line, enough lives will be saved to have made this essay worthwhile.

Four of the most useful contingency orders are as follows:

POTASSIUM CONVENTION—To keep potassium levels normal.

Space potassium chloride in the fluids according to the level determined at 6, 8, 12, or 24-hour intervals. Divide the total dose by the hour interval.

Potassium Level (mg/dl)	*Dose (MEq)*
Over 5.5	0
5-5.4	10
4.6-4.9	80
4-4.4	140
3.5-3.9	160
3-3.4	180

DIGOXIN CONVENTION—To keep digoxin level within normal limits—obtain daily digoxin level.

Level (mg/dl)	*Dose of Digoxin (mg)*
>2.8	0
2.5-2.7	0.125
2-2.4	0.25
1.5-1.9	0.5
1-1.4	0.75
<1	1.0

Use the schedule if the convention results in digoxin level under 2.8; half the schedule if BUN is over 30. Hold for instructions if potassium is under 3.5.

AMINOGLYCOSIDE CONVENTION—To prevent autotoxicity and nephrotoxicity from the aminoglycoside.

Divide dose of gentamycin, amikacin, tobramycin, or any other aminoglycoside by creatinine level as determined daily. Discontinue the antibiotic if creatinine rises two days in a row and seek physician's instructions. Obtain daily drug levels if creatinine is over two mg/dl.

PULMONARY ARTERY DIASTOLIC PRESSURE CONVENTION—To prevent fluid overload.

> **" 'Son, physicians should stay away from wakes and funerals—patients may make the wrong association.' "**

If pulmonary artery diastolic pressure rises five ml of mercury in an eight-hour period, give 50 mgm ethacrinic acid IV (if BUN under 30) and slow fluids to one half the rate. If BUN is over 30, give 100 mgm lasix instead.

These contingency orders exemplify many that physicians can devise for their units.[1]

CRITICAL CARE SOCIETIES

Finally, I would like to share with you some ideas that are based on ten years of experience with national and local critical care societies. First, the functions of a critical care society must be clear. The organization will fail if it is used as a ploy to get or give credentials that will help exclude some non-member physicians from their patients in the intensive care unit. There are too many well-trained physicians now for the continued proliferation of inhospital groups that are given an exclusive slice of each patient's care by fiat. I see a shift away from control of patient care by hospital administration back to the physician whom the patient has consulted. This will *not* be because many people agree that physicians should take more active care of their own patients, but it will be because the professors in medical school centers who train surgeons, particularly cardiac surgeons, nephrologists, chest physicians, oncologists, infectious disease specialists and cardiologists will teach their graduates that they can and should treat surgical complications, renal failure, shocked lung syndrome, gram-negative septicemia with shock, and patients with cardiogenic shock. Alas, many primary care residents also are being told the same.

The structure of the department system in American medical schools is too entrenched for the professors of surgery, anesthesia, cardiology, nephrology, and chest disease to give up their control of patients who become critically ill. Therefore, any dreams should be given up that critical care physicians will reach a point through their organizations when they will be designated "the doctor" who takes primary care of critically ill patients.

Critical care societies should be kept physician-oriented. The level of meetings must be at the physician level or he cannot and will not remain interested. The corollary to this is that physician members of the society must be willing to teach at meetings of the auxiliary personnel, all of whom have active local and national organizations. I cannot be the only physician who has noticed the difference in physicians' presentations when there is not a predominance of physicians in the audience. Busy critical care physicians *will* come to a meeting where they can learn the latest on brain death, shocked lung, or plasmapheresis, but they will not come when the meeting is toned down for paramedic understanding and where speakers are forced to dilute their presentations for the understanding of non-physician personnel. Thus, I think your main raison d'être should be to educate and teach each other.

Finally, stay away from death. Dr. Francis Murphy, my mentor in the practice of medicine, once told me: "Son, physicians should stay away from wakes and funerals—patients may make the wrong associations." And he was right. There is a whole "death establishment" developing now, and we should take the position that they "work their side of the street (but not in the critical care unit) and we will work ours." Those who are active in critical care long since have learned that dying is a part of living. It goes without saying that this knowledge becomes a part of our treatment equation. But, we should be very sure that a person waking up in a critical care unit knows in every way and by every action that he is there so that he can live and that his physician represents life, hope, and science. The critical care physician is not an angel of death.

SUMMARY

What is done for the patient not *who* does it is the important factor in the care of the critically ill patient. Critical care units should be constructed and operated in as open a manner as possible and each patient should have a view of the ouside with isolation of any kind being kept to a minimum. The physician in charge should write all the orders but need not be present physically the majority of the time. Contingency orders should be written in a manner that keeps potassium levels, digoxin levels, and antibiotic levels within normal ranges. The function of critical care societies should be to foster learning and teaching at all levels but these societies should not in any way serve to restrict the access to critically ill patients by their physicians. Critical care should be concerned with the living and the saving of lives—not with accepting and awaiting death.

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Waisbren BA: *Critical Care Manual: A Systems Approach Method,* 2nd Ed. Flushing, NY, Medical Examination Publishing Co., Inc., 1977.

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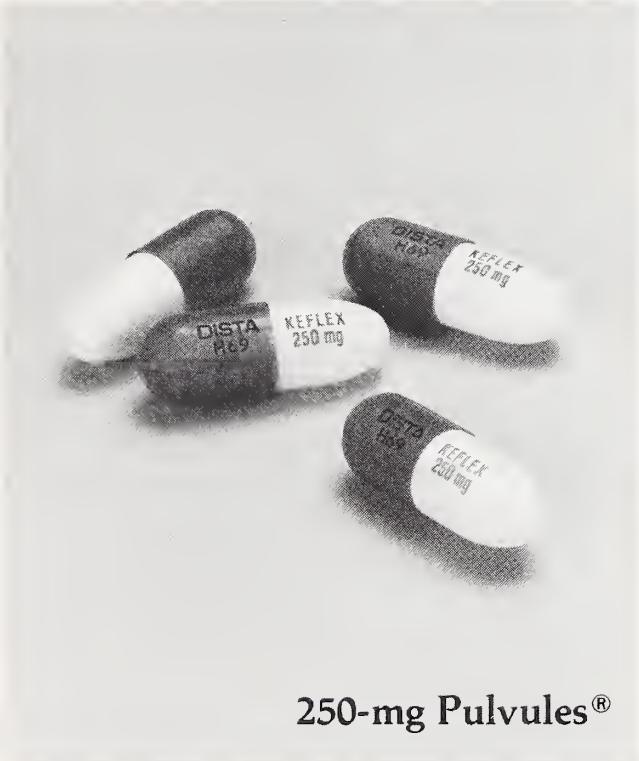

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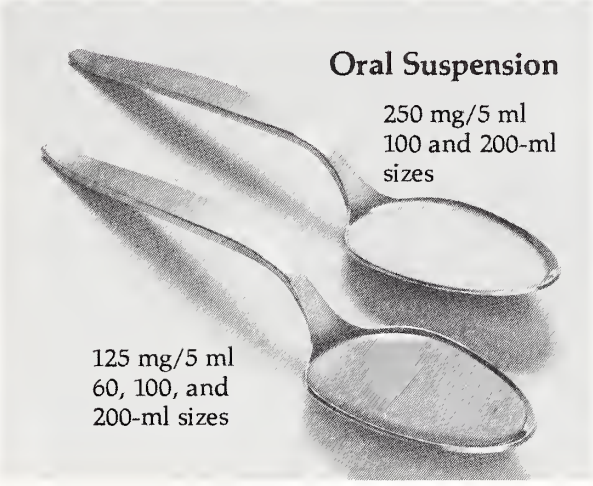

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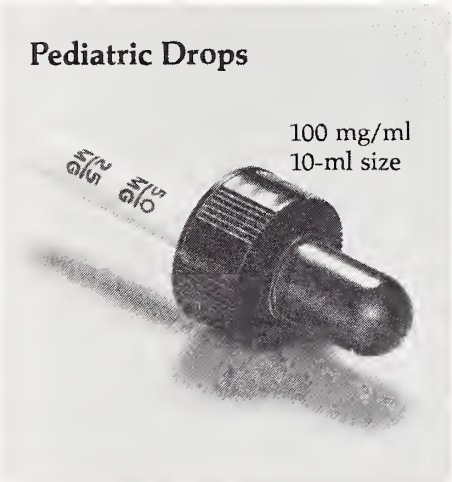

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Office Abortion: A Humane Approach to a Traumatic Experience

PHILIP S. GREEN, M.D., Dunellen*

The decision to have an abortion can be extremely difficult. Office abortion under local anesthesia, with close physician contact, is safe, tolerable, and preferable to hospital or clinic procedures under general anesthesia. Direct physician contact and counseling reduces anxiety and increases the acceptability and tolerance of the procedure.

Since voluntary interruption of pregnancy was legalized by decision of the U.S. Supreme Court in 1973, increasing numbers of women have chosen to terminate unwanted pregnancies. In 1977, over one million women elected to have abortions and the number still is increasing according to recent surveys.[1] It has been shown that an abortion prior to the sixteenth week of gestation is associated with lower mortality than carrying the unwanted pregnancy to term.[2] Originally, pregnancy termination centers were located in hospital settings, but outpatient clinic facilities have since multiplied and thus removed a great burden from hospital operating rooms. At the same time, many physicians began performing abortions as office procedures.

The candidate for an abortion is most commonly a young, frightened unmarried woman who would profit from personal contact with the physician for counseling, relief of anxiety, and explanation of the procedure. The proper approach requires tact, compassion, emotional support, and personal attention. These amenities frequently are lacking in "assembly-line" clinic facilities where patients are merely numbers. It is precisely this impersonal approach that intensifies the anxiety and guilt that is felt by these sexually inexperienced young women who have little knowledge of adequate contraception or the risks of venereal disease.

The decision to terminate pregnancy is psychologically traumatic to patients. The physician contact and his counseling help these patients to avoid future repetition.[3] It also can dispel the fear associated with the procedures by explaining the operation and its minimal risks. The need for postoperative followup in order to avoid major complications also must be emphasized.

Office performance of the procedure also reduces costs to the patient. Hospital charges range from $400 to $700 for the one-day admission; the fees of the anesthesiologist or anesthetist and the surgeon create a total near $1000. Most office fees range from $175 to $225.

Having been exposed to the hospital and clinic facilities, the author chose the office as the ideal site for pregnancy termination. The latter obviously offers so many advantages, primarily to the patient, but also to the physician.

METHOD OF PROCEDURE

All patients receive instructions prior to presenting themselves for the termination procedure. They are to be in a fasting state, and are advised to empty the lower bowel with a disposable enema. The patient should be driven to the office by a relative or friend since she is premedicated with an analgesic such as propoxyphene and acetaminophen (Wygesic®) and a tranquilizer, lorazepam (Ativan®) or

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Table I
Complications of Abortion [8-10]

	Reported Series Percent	Author's Patients Percent	Number
Infection	1.3	0.4*	6
Postoperative hemorrhage	1.3	0.0	
Perforation of uterus	0.1	0.0	
Cervical tears	0.03	0.0	
Undiagnosed ectopic pregnancy with postabortal rupture	0.1	0.0**	
Failed abortion	0.2	0.2***	3
Postabortion syndrome	–	0.2	3
Retained fragments of tissue	–	0.3	5

*One patient hospitalized
**0.1% (2 cases) diagnosed at time of abortion and operated prior to symptoms
***Reperformed after postoperative followup

Table II
Complication Ratio Related to Type of Anesthesia [5]

	General Anesthesia		Local Anesthesia
Uterine hemorrhage	1.7	:	1
Perforation	2.2	:	1
Intra-abdominal hemorrhage	8.2	:	1
Cervix trauma	2.9	:	1
Fever	1	:	2

diazepam (Valium®). Preoperative laboratory testing provides a blood type, Rh, and hemoglobin.

Surgical preparation is performed with a wipe of povidoneiodine (Betadine®) solution over the vulva, perineum and in the vagina. Sterile disposable gloves are used; no mask, gown, or scrub being required. The instruments used can be seen in a recent textbook on abortion procedure.[4]

Local anesthesia is used because of its convenience and less associated risk.[5] A minor drawback is that patients still have mild to moderate discomfort in the uterus at the time of vacuum aspiration which feels like menstrual cramps. If intolerable, this can be relieved by the intramuscular injection of meperidine (Demerol®) or nalbuphine (Nubain®) before continuing the procedure. Most often, the comforting of the patient by the physician and the assisting nurse relieves the patient by reassuring her of the short interval of discomfort.

The paracervical area is infiltrated with two percent mepivacaine (Carbocaine®). Originally a syringe with a spinal needle was used for injection, giving a total dose around the circumference of the cervix of 15 to 20 cc. At present, a pneumatic jet immunization gun, which has been adapted for vaginal injection, is being used. This reduces the total anesthestic solution by over 75 percent, thereby reducing the risk of absorption reaction.[6] The anterior lip of the cervix is also injected prior to its being grasped with a Jacob's tenaculum. Paracervical block tends to relax the resistance of cervical musculature and facilitates dilatation.

After adequate anesthesia is obtained, the uterus is sounded in order to confirm the size and direction of flexion of the fundus, which had been determined previously by careful bimanual pelvic examination. The cervix is then gently dilated with either Hegar or Pratt cervical dilators. The Pratt is more effective, if greater than eight mm dilatation is required, because of its more gentle taper with less tendency to lacerate the cervix.

Flexible whistle-tip plastic disposible curettes are used for terminations less than nine weeks, choosing the appropriate size according to the length of gestation (mm size of cannula required roughly corresponds to number of weeks gestation). A high-quality suction apparatus is necessary to achieve rapid high vacuum for speedy evacuation. Larger rigid cannulas are required for more advanced gestations and in these patients, 10 U. of oxytocin (Pitocin®) is given by intramuscular injection prior to the administration of the anesthetic. After the uterus has been emptied by suction, a sharp curette is gently passed over the uterine cavity to ensure its complete evacuation.

It is of utmost importance to be prepared for any major complication associated with the procedure. A ten-minute transport time to the nearest hospital is a reasonable requirement. Intravenous fluids, cortisone, adrenalin and oxygen by mask all should be available.[7]

Tissue removed is examined grossly to determine quantity and characteristics. To date, no molar degeneration has been encountered.

After completion of the procedure the patient is escorted to a couch where she is observed for fifteen to twenty minutes to allow time for the natural cramping associated with uterine involution to subside, to detect any excessive uterine bleeding and to complete the postoperative instructions. The patient may be accompanied at this time by her companion in order to ease the pscyhological trauma of this period. She is given prescriptions for analgesic and uterotonic agents and is advised to return for followup examination in ten to fourteen days. Rhogam® is given to all Rh-negative unsensitized patients. No antibiotics are given prophylactically.

RESULTS AND COMPLICATIONS

In the six years since the legalization of abortion, the author and his associate have performed approximately 1800 terminations of pregnancy in the office with minimal complications. The patients ranged in age from 13 to 44 years and in parity from zero to eight. They were of all marital states—single, married, separated and divorced and of all ethnic groups with the same distribution as usually seen in the author's practice. Some patients were aborted more than once during this period.

The complications most often cited are (1) infection, (2) postoperative hemorrhage, (3) perforation of the uterus, (4) cervical laceration, (5) undiagnosed ectopic pregnancy, (6) failed abortion, (7) postabortive syndrome (obstruction of the cervix by clots, cramps, and fever), (8) retained fragments of gestational tissue with continued slight to moderate bleeding requiring repeat aspiration.[8-10]

In the author's series, complications were less than average owing to insistence that the patient return for followup examination within ten days (See Table I). Two cases of ectopic pregnancy were diagnosed at the time of uterine evacuation since the tissue removed was minimal and revealed no chorionic villi and there was an associated adnexal mass. Both patients were subjected to laparoscopy and subsequent laparotomy.

"No patients had any serious reactions to the procedure requiring . . . oxygen, intravenous fluids or other drugs."

No patients had any serious reactions to the procedure requiring the administration of emergency measures such as oxygen, intravenous fluids or other drugs. There was a five percent incidence of postoperative vagal syncope which responded to ammonia inhalants.

Local anesthesia has proved its value over general anesthesia; there is less anesthetic risk and less risk of operative complications. Under general anesthesia the frequency of uterine hemorrhage, uterine perforation, cervical trauma and intra-abdominal hemorrhage is greater as compared to the occurrence when local anesthesia is used.[5] (See Table II). The higher incidence of fever may be related to the less strenuous operative effort, which tends to leave small fragments of tissue in the uterus and causes endometritis and infection. However this must be weighed against the diminution of the other often more serious complications, as a result of the less strenuous procedure.

DISCUSSION

The office approach to pregnancy termination offers many obvious advantages and has resulted in gratifying patient acceptance of the procedure. A major drawback to the office approach is the failure of major health insurance companies to pay for such a procedure. In New Jersey they will reimburse the patient only for a hospital-performed abortion. This is obviously very short-sighted considering the great disparity of costs previously quoted. The physician, in spite of the lack of formal training as an abortion counselor, is in many ways better prepared to handle the situation. The doctor has greater knowledge of anatomy and physiology, the risks involved, and the relationship of these risks to future childbearing and he or she is best equipped to present the various contraceptive options to the patient. The patient is greatly relieved by and appreciates this close contact with the physician, thereby making a traumatic experience a more comfortable one.

"A major drawback to the office approach is the failure of major health insurance companies to pay for such a procedure."

SUMMARY

Since the legalization of abortion by the United States Supreme Court, the author and his associate have performed approximately 1800 abortions in the office under local anesthesia, using the vacuum aspiration technique. Early abortion has been shown to be safer than carrying an unwanted pregnancy to term. Patients are premedicated to augment the local anesthetic and are observed closely postoperatively. Complications associated with the procedure have been minimized by extreme care on the part of the operator. No prophylactic antibiotics are used. Patient counseling referable to contraception and postoperative care can be carried out during the observation period and at the postoperative visit. The close association with the patient who remains awake and conversant during the procedure has reduced the psychological trauma and helped the patient tolerate what might be an extremely difficult experience.

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Delay in Hospitalization for Myocardial Infarction

RICHARD N. PODELL, M.D., Summit

The delay in hospitalization of patients with acute myocardial infarction was assessed for the years 1965-1966 and 1976-1977. The proportion of patients delaying twelve or more hours fell significantly. However, the proportion hospitalized in less than four hours did not decline.

The impressive decline in coronary heart disease rates in the last decade has stirred considerable interest in understanding its causes.[1-3] One pertinent factor which has received relatively little discussion is a possible change in the delay in hospitalization from the time of onset for acute myocardial infarction.[4] Because of the high incidence of potentially treatable arrhythmia during the first hours of myocardial infarction, shorter delays should result in lower death rates.[5-6] Our impression is that in recent years much information about myocardial infarction has been directed at both physicians and potential patients. Therefore, it seemed appropriate to try to assess whether the delay time for patients with myocardial infarction has actually changed.

We examined the records of patients with myocardial infarction hospitalized at Overlook Hospital between July 1, 1965 to June 30, 1966 and July 1, 1976 to June 30, 1977. Overlook Hospital, a 546-bed community hospital in Summit, New Jersey serves a population of 200,000 to 300,000 persons in the suburbs of Newark and New York City.

METHOD

All patients less than 76 years old, who were discharged with a primary diagnosis of acute myocardial infarction were identified. (ICDA 420.1 and ICDA 410 for 1976-1977). Among patients discharged, living patients were selected on a random basis until there were 100 cases for each year for which delays could be estimated. In addition, all patients who died in the hospital were evaluated.

Eligibility for the study required documentation of the diagnosis of infarction. This was defined as a history compatible with myocardial infarction plus either diagnostic electrocardiogram or cardiac enzyme changes. When EKG, enzyme, or historical data were ambiguous, the case was included if a consulting cardiologist stated in the chart that there was a definite myocardial infarction. Cases were excluded if symptoms of the acute myocardial infarction began after hospitalization, if the patient was transferred from another hospital or if the acute myocardial infarction was deemed by the attending physician to be secondary to atypical causes (e.g., severe aortic stenosis).

The author estimated delay from a review of the written record. One-fourth of the eligible cases were reviewed on two occasions at least three months apart to verify the reproducibility of the reviewer's evaluation of delay. Charts were reviewed during a six-month period with 1965-1966 batches alternating with 1976-1977 batches to prevent secular trend bias.

Delay was defined as the time between the onset of acute symptoms to the arrival at the emergency room or, when the emergency room was not used, to the hospital floor. The arrival time was noted in every chart. However, the time of

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Table 1
Patients Less Than 76 Years old With Discharge Diagnosis of Myocardial Infarction, Overlook Hospital 1965-1966 and 1976-1977

		Discharged Alive	Died	Total
Number with discharge diagnosis of MI	1965-6	181	39	220
	1976-7	234	26	260
Percent of charts selected for review which were found	1965-6	95%	80%	
	1976-7	99%	70%	
Percent of found charts which had MI diagnosis documented	1965-66	71%	79%	
	1976-7	75%	80%	
Percent of charts with documented MI that were eligible for analysis	1965-6	95%	100%	
	1976-7	93%	100%	
Percent of eligible charts for which delay was determinable	1965-6	95% (N = 100)	87% (N = 21)	
	1976-7	93% (N = 100)	87% (N = 13)	

onset had to be inferred from the physician's notes.

Estimating the time of onset is the most important and difficult part of the method. No precise standards or criteria for "onset" could be deduced from a review of articles on delay in myocardial infarction.[7-8-9] Therefore we chose to define "onset" as the time when coronary artery symptoms (usually chest pain) began to take on a crescendo quality of frequency or severity. Two case histories illustrated the method:

CASE REPORTS

Case A—(Onset-4 hours) The patient was well until *two weeks* prior to admission when he began to experience mild substernal chest pain on exertion. *One day* prior to admission and again *twelve hours* prior to admission, he had fifteen minutes of heaviness in the chest at rest. *Four hours* prior to admission the patient had severe, crushing chest pain with diaphoresis. The pain persisted for two hours after which it began to ease. *One hour* prior to admission, the pain again became severe, this time with radiation to the left arm and the patient called the rescue squad.

Case B—(Onset-12 hours) The patient was well until *two weeks* prior to admission when he experienced mild substernal chest pain on exertion. *One day* before admission, he had fifteen minutes of heaviness in the chest at rest. *Twelve hours* prior to admission the heaviness returned. Although it waxed and waned it generally became more severe over the next twelve hours. He was unable to sleep that night and took several aspirin. The next morning (one hour before admission) he noted palpitations and shortness of breath and called the rescue squad.

Both patients had symptoms for two weeks and their course is similar in several respects. However, in case B there is a clear sense of crescendo twelve hours prior to admission. This quality is not present in case A until four hours before admission. Therefore, the delay was defined as four hours for case A and twelve hours for case B.

Some subjectivity must be accepted in the assessment of delay. Therefore, two reviewers might reasonably differ on the delay assigned to a particular case. However, if each reviewer is consistent with his own sense of "crescendo" both should agree on the answer to the main problem, which is whether there was an overall *change* in the delay between 1965-1966 and 1976-1977.

In six percent of otherwise eligible patients, the delay was indeterminate either because the history was not sufficiently detailed or because no crescendo pattern occurred. These cases were excluded from the tabulation of delay.

Frequently, symptoms were noted to have occurred "on the way to work" rather than at a specific hour. Therefore, arbitrary but reasonable times for daily events were defined prior to the review. For example "on the way to work"=7-9 am; "while eating breakfast"=7-8 am. The midpoint of these intervals was used to calculate delay.

Cases were aggregated into short delay (less than 4 hours), medium delay (4-12 hours), or long delay (12 or more hours). Differences between the years in the proportion of patients in each category of delay were assessed by the method of x^2.

RESULTS:

Reproducibility and Sampling—Of the fifty-four charts evaluated on two occasions three or more months apart, fifty cases were classified in the same delay category both times. Two discrepancies resulted when small differences in the assessment of delay altered the classification (e.g., from a medium delay of 11 hours, 50 minutes to a long delay of 12 hours, 10 minutes). Two discrepancies resulted from gross misreadings and were reconciled when the history was reviewed again.

For patients discharged alive, there was little difference between 1965-1966 and 1976-1977 in the proportion of charts where the diagnosis of myocardial infarction could not be documented (about one quarter) and in the proportion where the period of delay could not be determined (six percent).

Table 2
Delay in Hospitalization after Onset of Acute Symptoms, Percent Distribution

	Delay Hours			
	Short Delay (0-4 hours)	Medium Delay (4-12 hours)	Long Delay (12+4 hours)	Total
Patients discharged alive				
1965-6***	54	8*	38**	100% (N = 100)
1976-7***	49	26*	25**	100% (N = 100)
Patients dying in hospital				
1965-6	62	10	28	100% (N = 21)
1976-7	62	23	15	100% (N = 13)

*Difference in proportion of medium delay significant by x^2 (df = 1) – P < .01

**Difference in porportion of long delay significant by x^2 (df = 1) – P < .05

***Difference in all delays between 1965-6 and 1976-7 significant by x^2 (df +2) – P < .01

The proportion of charts which could not be found differed but was small in both years—five percent for 1965-1966 and one percent for 1976-1977. For patients who died in the hospital, there was no difference in the proportion where myocardial infarction could not be documented, or in the ability to determine the delay.

DELAY

Among patients discharged alive, 100 cases were evaluated for each year. The result showed no increase between 1965-1966 and 1976-1977 in the proportion of patients with delays of less than four hours. (Actually, there was a small, non-significant decrease in short delays). Nevertheless, the overall delay was significantly less in 1976-1977. (P< .01). This is attributable to a reduction in patients with long delays (12+ hours) (P< .05) and an increase in the proportion with medium delays (4-8 hours) (P< .01) For patients who died in the hospital, N is much smaller, and the differences are not significant; however a similar pattern appears.

DISCUSSION

The investigator had anticipated that public and professional education, which appeared to have increased in recent years, would have resulted in uniformly shorter delays in 1976-1977 than was the case during 1965-1966. Therefore, the actual results caused surprise and confusion. The results imply that long delays were less frequent, but short delays no more frequent in 1976-1977 than in 1965-1966. Overall, there was some trend to shorter delays, but it was completely confined to an increase in medium delays at the expense of long delays.

If we accept the validity of this study for the Overlook Hospital community, and if we postulate that in the light of further studies, Overlook's experience proves typical, then we face a puzzling question: what could cause long delays to decline while leaving the proportion reaching hospital in less than four hours unchanged? There are several possibilities, but one is particularly interesting in its implications for educational strategies designed to reduce delay in hospitalization for myocardial infarction victims.

The author's expectation that public and professional education would result in uniformly shorter delays was based on a simple and, in retrospect, naive model of the decision-making process which determines the patient's decision to call for help. It is well established that the physician delay and the transportation delay is *usually* small compared to the delay in the patient's decision to seek medical care.[10-11] I assumed that the more the patient understood about myocardial infarction symptoms and the importance of early treatment, the shorter would be the patient delay; therefore, more knowledge should shorten the total delay as well.

Unfortunately, for this reasoning, the patient's delay in seeking medical care is influenced by several factors, only one of which seems likely to be highly responsive to increasing knowledge. Among the factors contributing to the patient's delay are:

a. *Not knowing:* The patient might not know that a particular symptom, e.g., exertional chest pain is suggestive of coronary disease. This factor should be highly susceptible to influence by the knowledge transmitted through public education.

b. *Indecision:* The patient knows in general what kinds of symptoms might indicate acute coronary disease, but is unable to decide whether the vague, mild or atypical symptoms he is experiencing actually fits the suspicious category, e.g., is it coronary chest pain or just "gas" or a muscle sprain?

c. *Psychological defenses:* The patient might be unwilling to accept emotionally the intellectual conclusion that a myocardial infarction is happening to him.

Indecision and *psychological defenses* would seem likely to be more important during the first hours of an attack. The ambiguity of the early acute symptoms in many cases is genuine, and denial and other rationalizations against unpleasant facts are well known as common responses to medical and other forms of potential or real disaster.[12-13] The effect of factual learning on decreasing the duration of indecision has not been assessed so far as we know. However, I suspect that at least in the early stages, the effect of prior teaching on shortening the delay from indecision would be modest. Similarly, the literature on psychological defenses provides little encouragement that simply knowing about myocardial infarction symptoms would diminish the initial intensity or duration of denial or rationalization.[14-15] If these assumptions are correct then we should not be surprised that public and professional education might have little influence

". . . physician delay and the transportation delay is usually small compared to the delay in the patient's decision to seek medical care."

"Indecision and psychological defenses would seem likely to be more important during the first hours of an attack."

on decreasing delay below four hours. However, if, as one might expect, the power of indecision and psychological defenses diminish as symptoms persist, longer delays should become less frequent (and therefore medium delays more), which are the results we found.

To be sure, one should not go too far in generalizing from the results of one assessment in one hospital. However, the question of whether delay is changing is an important one, which has not been studied well. It would seem capable of evaluation by the methods used here despite such limitations as inter and intrareviewer variability, lack of information on persons who die from myocardial infarction before reaching the hospital, and on those who suffer so-called "silent myocardial infarction" or who are treated at home.

SUMARY

The majority of coronary heart disease deaths occur before the patient reaches the hospital. Therefore, shortening the delay before hospitalization should result in lower mortality.

The delay in hospitalization after the onset of symptoms was assessed by reviewing the records of patients hospitalized with myocardial infarction in 1965-1966 and in 1976-1977. The results show a significant decrease in the proportion of patients for whom delay was twelve or more hours. However, there was no increase in the proportion of patients hospitalized within four hours.

Possible reasons for the pattern of delay reductions are discussed, as are the methodological difficulties of this kind of retrospective study.

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Winter Itch, Dry Skin

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Loss of moisture from skin in winter produces itching, scaling and distinctive lesions which are easy to recognize. Acute care is with topical corticosteroids, but therapy and prevention require changes in the living environment and personal skin-care habits.

Even though Dame Rumor whispers that the Jersey Devil lives in our State's pine barrens, there are those among us who know better. He vacations there only until the temperatures drop; then he heads elsewhere to resume his real work. The people who know this certainty, are convinced that he winters in their skin. And like "old Nick" himself, he takes on many guises to spread his miseries more effectively, and to confound those who would exorcise him. For recognition is his bane! Healers can, and do, cast him out, often to the accompaniment of mystical, polysyllabic incantations, otherwise known as dermatological diagnoses. But if the inner secrets of the brotherhood were revealed, included would be the knowledge that these priestly adjurations are so much showmanship and are not required for success. Even without uttering such strange sounds, the citizens of New Jersey can be delivered and the demon sent packing back to Canada, or wherever he comes from. Winter itch, our seasonal Jersey Devil, is an understandable, recognizable, treatable and preventable condition.

UNDERSTANDING

With winter comes the bandit trio of falling temperatures, falling relative humidity and rising winds. By encouraging the movement of moisture through the skin and into the environment, they steal the essential ingredient which is needed for the integrity and flexibility of our outer horny layer of protection. For it is water, rather than the oils manufactured by the skin, which maintains its healthy state.[1] Deprived of water, our armor develops the chinks which are recognizable as the signs and symptoms of dry skin.

If the rigors of a hostile environment were not enough, additional damage comes with the otherwise admirable quest for perfect cleanliness. Sybaritic visions of several daily washings with scented soaps, of luxuriating in a hot tub surrounded by billows of suds, strike sympathetic chords with advertisers and movie producers. The scene is less attractive to the truly enlightened observer. Soaking in water, particularly with added detergents, removes the soluble compounds within the skin which avidly bind moisture.[2] Stripped of these natural moisturizers, the skin is even more at the mercy of a dry environment.

Certain people are exposed to particular risk, and their skin-dessicating activities seem obvious. The arthritic, for example, relieves stiff, aching joints with soothing hot water soaks or showers. The young child is kept happily occupied romping through toy naval maneuvers or rubber-fowl round-ups, in a tub full of water. The all-year swimmer, either in practice, or for healthful exercise, strokes laps in a pool of chlorinated water. These are all individuals with a great potential to develop winter itch. The growing fad for com-

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munal or *au pair* dipping in oversized wooden vats, and the use of water-pulsating shower heads can only swell the size of the population at particular risk. Most sufferers, however, are "average people" who consider that they are not doing anything special or excessive.

RECOGNITION

Rarely do patients appreciate the true nature of the winter itch, dry skin problem. Their complaints range from a description of itching and lost sleep, to a plea to rid them of a rash that suddenly developed. At first glance, many do not appear to have any gross abnormality of their skin. Only close inspection in adequate, tangential light, may reveal a general, fine, dry flaking. It is easier to see on black skin or when pigmentary changes accompany the scaling. In darker skinned people this often takes the form of hypopigmentation, lighter islands of skin, surrounded by the more heavily pigmented normal skin. The adjective "ashy" sometimes used by the patients to describe this type of skin, is a remarkably apt picture. Discrete well-demarcated oval or round, scaly, light-colored patches of one to several inches in diameter qualify for the title of "pityriasis alba." The term sounds impressive, but it simply translates to fine whitish scaling.

Sometimes the patch of dry skin takes on the appearance of goose-flesh. This represents an exaggerated drying reaction of the hair follicle structures in the area. Fine scale accumulating in the pores forms uniform pin-point cones, all evenly spaced from one another. This pattern can be called "keratosis pilaris," which describes horny accumulations in the hair follicle, nothing more.

If sufficient inflammation accompanies the drying process, redness is superimposed on the patterns, producing the variety of rashes that bring on the search for professional assistance. Severe inflammation may take the form of small blisters or superficial erosions, accompanied by cracking, and oozing exudates, all the hallmarks of acute dermatitis or eczema. When the more severe redness and flaking and/or oozing patches show small blisters and assume round or oval forms, the term "nummular eczema" applies. This only alludes to the coin-shaped outlines of the lesions, and has no added meaning with regard to the cause of the condition. A peculiar, net-like pattern of superficial cracking, erosion and redness, said to resemble old porcelain china, is "eczema craquelée." The condition occurs on the lower legs and is an additional variation of the basic, dry skin theme.

Should there be the wish to confer unnecessary grandeur and respectability to winter itch(prurigo)/dry skin the terms "eczema hiemalis," "xerotic eczema," and "asteatotic eczema" wait in reserve for those who would evoke the antique languages. This condition is often justifiably equated with "mild atopic eczema," and questioning may reveal a past or family history which confirms this.

TREATMENT

The immediate goal of treatment is relief from itching and/or the unsightliness of the affected skin. The topical corticosteroids accomplish this task with remarkable fidelity and ease, so much to the point, that the user adopts the wonder drug for either continuous application, or to treat any and every skin affliction that may arise thereafter. With this in mind, it is prudent to prescribe small quantities of the more potent fluorinated corticosteroid products, since they are most likely to produce unwanted adverse effects with improper use. In many instances one percent hydrocortisone preparations may be all that is necessary, and these can be offered with more assurance that they will not be abused. In any event, the fluorinated steroids should be avoided, whenever possible, when treating very susceptible parts of the body such as the face, or intertriginous areas (groin, axillary, inframammary regions.) Absorption of the drug is enhanced in these areas, as is the potential for local side effects. Unsightly reactions occur, such as redness with acne-like pimples of the face, particularly right around the mouth. Elsewhere on the body the steroids may cause thinning, pigment loss, dilation and exaggeration of superficial blood vessels and purplish or scar-like cracking of the skin.

Some attention should be given to the choice of dosage form as well. Ointments, while salubrious for dry, flaky skin, macerate when used on intertriginous areas and produce new irritation problems. Creams or lotions might be better suited for the warm, moist, rubbing parts of the body, as well as for use in hairy regions.

When itching is very severe, supplementary systemic medication may be indicated. Since the discomfort seems to be most intense at bedtime, often interfering with sleep, the choice of hydroxyzine (Vistaril® or Atarax® is appropriate. With antihistaminic, antipruritic activity and tranquilizing properties, its use just before retiring provides the needed relief. Advice to avoid taking the drug during the day, when drowsiness can be dangerous, should be emphasized.

Occasionally, systemic antibiotic therapy is also required. The signs that superficial infection has been superimposed on the lesions or scratched skin, include the following: frank pus, oozing, sticky yellow exudates or dried yellowish crusts, all attended by additional redness and discomfort. Cultures and bacterial sensitivity tests can be taken and a seven-day, full-dose course of erythromycin started. In most instances, the offending organism will be a gram-positive coccus which is susceptible to the drug.

Resist the temptation to charge in with other stern local measures to treat the infection. Excessive scrubbing with antibacterial soaps may only aggravate the underlying dry skin problem.

PREVENTION

Education is the key to the management of winter itch, dry skin problems. If there is to be intelligent cooperation in the prevention regimen, the person involved, and other key members of the family or living environment, must understand why and how the condition develops. The measures that are to be taken to prevent recurrence then become logical and acceptable. Lifelong habits may have to be changed; old beliefs may be challenged. Personal communication is the only way to obtain required feedback and to instruct and convince. Printed instuction sheets are a valuable supplement, but they should not be used as a substitute for the face-to-face counseling session.

Inquire about the bathing habits: the frequency, method, duration, use of very hot water. Unless there is an occupational (or recreational) reason, daily, ritual bathing during the winter months should be discouraged. Suggest alternate day, quick (five minute) warm-water showers. Discourage tub bathing, even if bath oils are added. The oils are of doubtful assistance, floating on the surface, while the body is submerged and exposed to the leaching effect of the water. Detergents added to disperse the oil throughout the bath will only enhance the moisture-stripping properties of the soaking.

What kind of soap or detergent is used for washing? Many

people will quickly tell you which products do, in fact, make the dry skin worse. In general, the antibacterial soaps are apt to promote the dryness and irritation. Identify these for the individual who does not associate specific brands with antibacterial properties. The mildest products are those which seem to disappear quickly in daily use. These include the glycerine-containing, translucent soaps (Neutrogena®, Purpose®, Pears®) and the detergent bar, Dove®. These are very water-soluble products, whose performance is better tolerated by the winter itch, dry skin.[3]

Most emollients can be used to improve the look and feel of the dry skin. These preparations are primarily oil in water emulsions which leave a fine layer of lipid substance on the surface to fill the minute cracks and uneven topography of the affected skin. Since they probably help to seal in some moisture as well, recommend their use immediately after a shower, while the skin is still damp. Examples of this type of product include Nivea®, Nutraderm®, Lubriderm®. Vaseline Intensive Care®, and Keri Lotion®. Recently, preparations have been developed which contain additives which are "natural moisturizers." Creams and lotions with urea (Aquacare®, Carmol®) or lactic acid (Lacticare®, Purpose®) seem to offer advantages to very dry skin.[4,5] If they are applied to broken or denuded areas, however, burning, itching or stinging may result from the added chemical ingredients.

Finally, steps should be taken to increase the humidity in the home environment. Recommend a cool-vapor mist humidifier for use in the bedroom where most of the time is spent. These small machines are relatively inexpensive ($15 to $20) and are worth the investment for both remoisturizing the skin and protecting the mucous membranes of the nose and throat from the parching winter dryness. With efforts to reduce heat at night, to conserve energy, temperatures drop to the point where the older steam vaporizers only serve to put out a fog that quickly condenses and drops to the floor. Likewise, the intermittent flow in hot air, humidifier-augmented systems, fails to deliver the amounts of moisture that will soothe and protect.

Feel confident to use the winter itch, dry skin regimen with wild abandon. It will even help in those rare instances where the diagnosis may have been inappropriate. Like mother's chicken soup, "It can't hurt!"

SUMMARY

Very common skin problems erupt each winter due to the drying effect of the low relative humidity in the environment, and, paradoxically, from overexposure to water. The combined effect is the loss of moisture which is required to preserve the integrity of the skin. Winter itch, dry skin usually appears as barely perceptible scaling, sometimes with hypopigmented areas, or patches resembling goose flesh. More acute inflammatory lesions can be red, and/or oozing, assuming discrete annular or oval shapes; or, on the lower legs, as large irregular areas of cracking and redness. It is emphasized that each presentation is a variation of the same basic problem and that all respond to a rather simple program of treatment. Topical cortisteroids are the mainstay of the therapy for the more severe forms. The milder manifestations are managed by increasing the humidity in the home and changing those habits of personal hygiene which tend to dry out the skin. Continued attention to these factors is important for preventing recurrences of the disorder.

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Massive Metastatic Cardiac Tumor Encasement with Pericardial Constriction*

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A case of massive cardiac constriction due to metastatic carcinoma with obliteration of the pericardial sac from a clinically silent primary adenocarcinoma of the lung is reported. To our knowledge this is the largest recorded example of metastatic cardiac tumor in the literature.

The most significant tumor involvement of the heart and pericardium is metastatic malignancy. Metastatic tumors to the heart are 20 to 40 times more common than primary growths.[1] Clinical manifestations of these tumors usually are rare and more often due to pericarditis than to the direct effect of the tumor itself.[2] Neoplastic cardiac tamponade, a very important emergency in clinical oncology, occurs in approximately 1.5 percent of cases of cardiac metastasis.[3] The usual cause of the neoplastic cardiac tamponade is a malignant pericardial effusion. Only rarely does constriction develop from a tumor that encases the heart.[4] The following case documents a patient with cardiac constriction due to metastatic bronchogenic carcinoma which obliterated the pericardial sac. The magnitude of tumor involvement was massive, producing a heart weight of 1510 grams.

CASE REPORT

A 59-year-old female was admitted for evaluation of increasing shortness of breath and occasional episodes of chest pain.

One month prior to admission the patient was seen by her private physician for a viral-type upper respiratory infection. Subsequently, the patient noted progressive, severe peripheral edema, marked orthopnea and shortness of breath to the point that she was essentially bedridden. In addition to vague atypical precordial pain, she complained of mid-epigastric pain exacerbated by coughing and deep breathing. There was no prior history of cardiac or pulmonary disease, gastrointestinal or liver problems. Her habits included excessive alcoholic consumption for several years and heavy cigarette smoking for 30 years. A chest roentenogram two years prior to admission revealed normal cardiac size and clear lung fields. (Figure 1a)

The patient was an obese, chronically ill female in moderate respiratory distress with marked orthopnea. Blood pressure was 110/60 with a pulsus paradoxus of 25 mm of mercury. Pulse was 100 and regular, respirations were 30, and temperature 98 degrees Fahrenheit rectally. The skin was cool and slightly diaphoretic. Neck veins were distended. The lungs were dull to percussion at both bases; breath sounds were decreased with slight expiratory wheezing. Palpation of the heart disclosed a diffuse right ventricular impulse and tapping faint left ventricular impulse at the apex within the mid-clavicular line. The first and second heart sounds were of good quality and amplitude, with a soft third heart sound

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Figure 1a—Normal chest roentengram two years prior to admission.

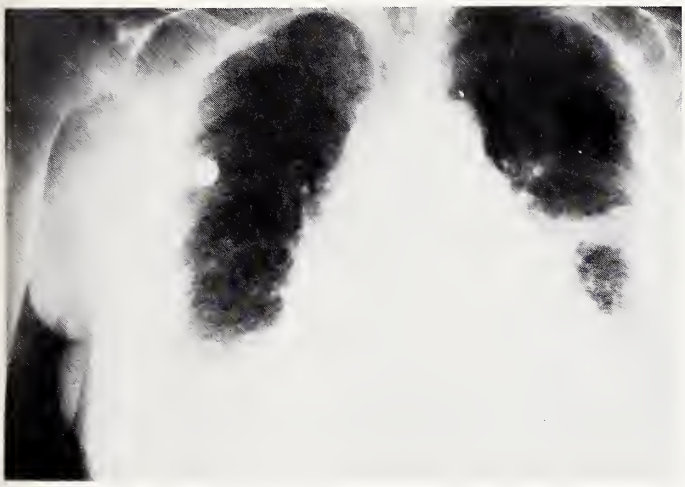

Figure 1b—Chest roetengram showing a massively enlarged cardiac silhouette, bilateral pleural effusions and generalized increase in vascular markings during final admission with atelectasis in the left lung.

at the apex. There was no murmur or pericardial rub. The abdomen was obese and the liver markedly enlarged with a non-tender smooth firm edge. The extremities showed 3+ pitting edema midway up the tibia.

Laboratory data revealed abnormal liver function with alkaline phosphatose 135 units, LDH 1080 units, SGOT 230 units and bilirubin 2.0 mg/dl. Complete blood count, serum electrolytes, creatinine phosphokinase, prothrombin time, serum ammonia, sedimentation rate and thyroid function studies were all within normal limits. The chest x-ray showed a marked difference from 1977 in that the heart now appeared massively enlarged. There was bilateral pleural effusion, atelectasis of the left lung and generalized increase in vascular markings (Figure 1b). EKG showed sinus tachycardia with normal voltage and non-specific ST-T wave changes.

On admission, the diagnosis was felt to be probable congestive cardiomyopathy with a question of superimposed physiologically significant pericardial effusion. The patient was treated with digitalis, diuretics, topical nitrates and salt restriction.

Echocardiography was technically difficult. A gated cardiac blood pool scan revealed a diffusely hypokinetic left ventricle which was somewhat smaller size than predicted by chest x-ray. Diagnostic thoracentesis yielded fluid with protein of 2.5 g/dl. and many lymphocytes. Cytology and cell block were negative for malignant cells. Serial chest x-rays and electrocardiograms remained unchanged. Clinically, the

"Virtually every form of malignancy has the potential to metastasize to the heart, however, over half of these metastases originate from primary tumors in the breast or lung."

patient suffered with dyspnea, orthopnea, and incessant cough, despite therapy. Right heart catheterization documented a mean right atrial pressure of 18 mm of mercury, pulmonary arterial pressure of 55/18 mm of mercury, and mean pulmonary capillary wedge pressure of 22 mm mercury. Positioning of the catheter against the endocardial surface of the right atrium appeared to document a very large pericardial effusion with a wide space between the radiopaque contrast material and the lateral border of the right atrium on fluoroscopy. A therapeutic pericardiocentesis then was attempted, however, multiple attempts to obtain fluid were unsuccessful. The patient's condition continued to deteriorate and she expired on the 16th hospital day. Easily audible heart sounds of good quality and a prominent tapping right ventricular impulse were present until death.

Autopsy revealed a 1.7 cm subpleural, irregular gray and firm dominant tumor mass located in the right upper lung. Histologically, the tumor was a mucin-producing adenocarcinoma. Widespread lymphatic spread of tumor was evident in all lobes. The mediastinal and paratracheal nodes of both sides were enlarged and grossly and microscopically involved by tumor. Bilateral pleural effusions (approximately 850 cc) were present.

The dramatic findings were in the heart. It was enlarged, weighed 1510 grams and occupied most of the lower chest cavity, especially the left side where it extended close to the chest wall. The parietal and visceral pericardium were massively involved by tumor with obliteration of the pericardial space. The tumor involvement was diffuse and solid, totally encasing the heart with marked thickening of the walls of all chambers (Figure 2). The thickness in the atria was 1.5 cm and the ventricles up to 2.5 cm. The actual thickness contributed by the left ventricle muscle devoid of tumor was 1.4 cm, and the right ventricle 0.3 cm (both within normal limits). The size of the chambers as well as the valve rings were within normal dimensions. The myocardium was uninvolved except superficially and only focally. The gross appearance was suggestive of mesothelioma rather than metastatic carcinoma. Veins entering both atria were compressed by tumor. Histology revealed a mucin producing adenocarcinoma, mostly of signet ring cell type. Extensive lymphatic involvement was noted. Superficial myocardial involvement by tumor was present only in the lymphatics. The coronary arteries were moderately sclerotic.

The abdomen contained 500 cc of ascitic fluid. Centrolobular necrosis of the liver was prominent. No metastatic or primary neoplasm was encountered in any other site.

COMMENT

Virtually every form of malignancy has the potential to metastasize to the heart; however, over half of these metastases originate from primary tumors in the breast or

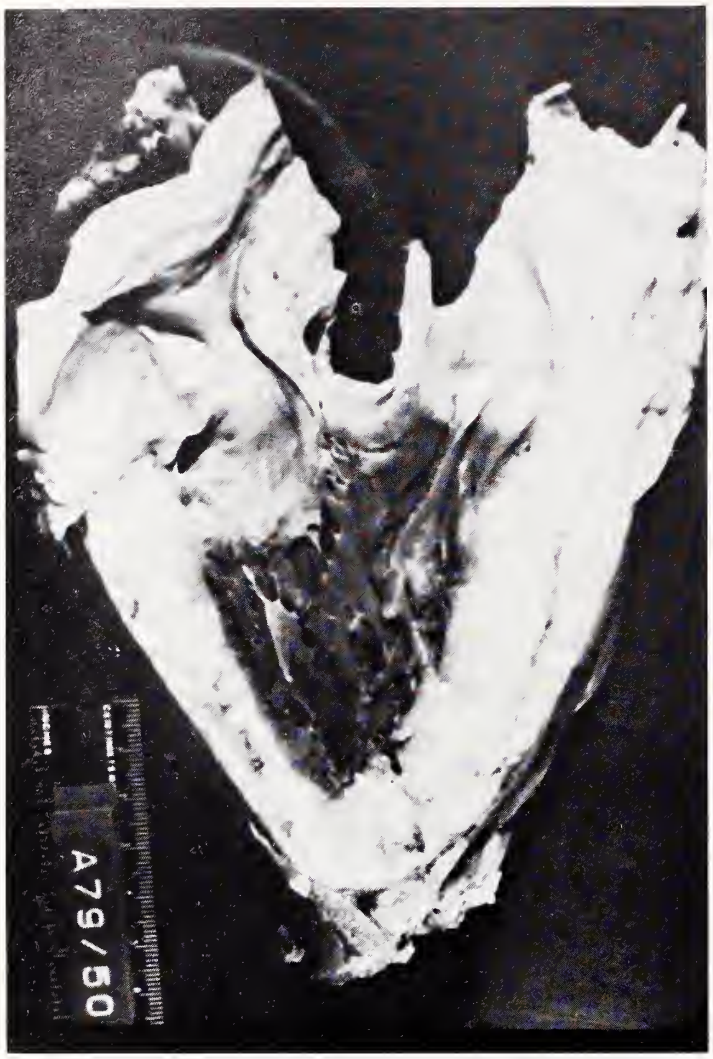

Figure 2a—Longitudinal section of the heart through the right side chambers.

Figure 2b—Longitudinal section of the heart through the left side chambers.

lung.[5,6] The prevalence of metastatic cancer to the heart has been reported as 0.5 to 19.1 percent of all malignancies, excluding leukemias. [2,6,7] Metastatic tumors to the heart are rarely diagnosed before autopsy largely because there is little knowledge of their natural history and because they rarely cause clinical heart disease.[2,8] In the majority of patients with pericardial metastases, the diagnosis usually is made antemorten only when there is myocardial compression and tamponade. However, the diagnosis may be difficult, especially when tumor encasement, not pericardial effusion, causes hemodynamic decompensation.

Constrictive pericarditis due to tumor is an uncommon condition. Among several large series of metastatic cardiac tumors, the frequency of actual mechanical constriction varies between one percent to 11 percent.[6,11] Earlier studies have revealed that a large majority of the hearts involved with metastatic tumor weighed less than 350 grams.[12,15] Gassman previously reported the two largest hearts due to metastatic carcinoma with weights of 850 and 780 grams.[7] Our case report, with a heart tumor weight of 1510 grams (to our knowledge) is the largest in the literature of metastatic cardiac tumors. Moreover, the increased heart weight was caused solely by tumor since there was no left ventricular or primary chamber enlargement.

Constrictive pericarditis occurs in various forms. Hancock described three forms of compressive pericardial disease: cardiac tamponade, subacute constriction in which the heart is constricted by fibroelastic scarring often with associated pericardial effusion in various stages of loculation and organization, and chronic constriction in which a fixed-volume rigid shell surrounds the heart.[16] Mann *et al.* have recently emphasized the increasing frequency of subacute effusive-constrictive pericarditis due to metastatic malignancy.[17]In their series, two patients with hemodynamic data suggestive of pericardial constriction had unsuccessful attempts to obtain fluid by pericardiocentesis. The authors concluded that these two patients represented one end of a spectrum of effusive-constrictive involvement with constriction due to tumor being the predominant cause of cardiac dysfunction. Our case was similar to these two, however, the differentiation from infiltrative cardiomyopathy with accompanying effusion was impossible to make antemortem. The fact that diastolic pressures throughout the heart differed by less than six mm Hg was supportive of constriction, however, the pulmonary artery pressure (55/18 mm Hg) was more supportive of restrictive cardiomyopathy in which one frequently finds a pulmonary artery systolic pressure greater than 50 mm Hg.[18] The distinction between these two entities often is not made until thoracotomy or, as in the present case, autopsy.

Many clinical findings in our case are commonly found in constrictive pericarditis as described in a recent review by Hirshmann.[18] Distended neck veins, an enlarged liver, peripheral edema and ascites (noted at autopsy) are seen in over 70 percent of cases. The third heart sound which was appreciated in our patient at the apex is heard in 40 percent of cases. No diastolic knock was heard along the left sternal border. A pulsus paradoxus, as we consistently demonstrated

". . . with malignant pericardial involvement the heart sounds might remain clear and loud probably due to good sound transmission . . ."

"In our case, mechanical constriction of the heart by such massive tumor involvement was certainly the predominant mechanism of cardiac decompensation . . ."

in our patient, is present in only one-third of patients with pericardial constriction. Nonspecific ST-T wave changes are the most common electrocardiographic findings in pericardial constriction and an enlarged cardiac silhouette on chest x-ray is seen in 40 percent of cases.

Calcification is present in the pericardium in half the patients with constrictive pericarditis and it reflects the duration rather than cause of pericardial constriction. Since metastatic tumor does not cause pericardial constriction for a long period of time because of its natural history, the absence of calcification in our case is consistent with this fact. An interesting observation in the present case was the preservation of good quality heart sounds. Theologides, in a recent and very extensive review of neoplastic cardiac tamponade, stated that although heart sounds are weak and distant with pericardial effusion, with malignant pericardial involvement the heart sounds might remain clear and loud probably due to good sound transmission through neoplastic bridges between the visceral and parietal pericardium.[19]

Failure to detect the primary lung carcinoma on chest x-ray may have been avoided if lordotic views were taken because the postmortem location of the tumor was in the right apical area. Also, tomographic films of the chest in any case of suspected metastatic cardiac tumor is indicated since lung primaries are among the leading causes of metastatic heart disease. In addition, mammography is an additional diagnostic tool to be utilized since breast carcinoma also comprises a large percentage of tumors which metastasize to the heart in females.

Although equalization of diastolic pressures was documented by bedside right heart catheterization, no recorded trace forms of good quality were available for review. One would expect a deep right atrial y descent and, concurrent with this, a deep diastolic dip in the right ventricular pressure as rapid filling begins. This pressure quickly rises to a plateau as the rigid pericardium impedes further filling.[18] An echocardiogram was technically difficult to perform on this patient. Various echocardiographic features have been reported in the diagnosis of constrictive pericarditis. Rapid posterior movement of the left ventricular posterior wall in early diastole, followed by a flat mid to late diastolic motion, has been described by Feigenbaum[20] and found by Voelkel to be the most consistent finding in his series of patients with constrictive pericarditis.[21] However, this possibly may occur in patients with restrictive cardiomyopathy.[20] Gibson *et al.* noted abnormal interventricular septal motion characterized by a rapid anterior displacement of the left ventricular septal echo at the time of the QRS complex followed by a rapid exaggerated posterior motion in early diastole.[22] Abnormal septal motion, however, has been seen in patients with ischemic heart disease, conduction defects or right ventricular volume overload.[20] Schnittger *et al.* demonstrated pericardial thickening with or without pericardial effusion by M-mode in their patients with constrictive pericarditis, but no pathognomanic pattern of pericardial thickening diagnostic of constriction was found.[23] Other features reported in constrictive pericarditis include abnormally rapid $E\text{-}F_0$ slope on the anterior mitral valve, [20,23] duplication of the mitral valve, and premature pulmonic valve opening.[20] Although none of these echocardiographic findings are pathognomanic of constriction and the specificity and sensitivity needs further definement, the presence of one or several of the above findings, together with the proper clinical situation, are most suggestive of constriction. Recently, two-dimensional echocardiography has been employed in evaluating the intrapericardial space in patients with constrictive pericarditis to detect pericardial adhesions along with fluid.[24] Its value will need further testing.

There are several mechanisms by which malignant neoplasms involving the pericardium could interfere with normal cardiac function. Cardiac tamponade may result from pericardial effusion. Mechanical constriction of the heart by tumor tissue is another matter as is interference with the inflow or outflow tracts of the heart by encroachment on the great vessels as they pass through the pericardial sac. Rarer causes of abnormal cardiac function are interference with coronary circulation by (a) compression from without of tumor involving the pericardium, (b) neoplastic embolism within the coronary arteries, or (c) direct invasion of the coronary arteries and encroachment of the nerve supply of the myocardium.[5] In our case, mechanical constriction of the heart by such massive tumor involvement was certainly the predominant mechanism of cardiac decompensation, however, interference with the inflow tracts of the heart was also evident since veins entering both atria were compressed by tumor. No myocardial infiltration by tumor or coronary artery involvement by tumor was noted at autopsy.

It is often difficult to diagnose neoplastic cardiac encasement with constriction antemortem as an isolated entity. If a primary neoplasm is present in the clinical setting of cardiac constriction, the diagnosis should be entertained seriously. In the case report, a primary bronchogenic carcinoma was clinically silent since it was undetected on chest x-ray. Clinical and laboratory data were suggestive of a pericardial constrictive process, but the presentation was atypical for either pericardial effusion with tamponade or biventricular failure with uniform elevations of diastolic pressures. Results of the gated cardiac blood pool study supported the former diagnosis with a left ventricle appearing smaller than predicted by chest x-ray.

Although relatively rare and difficult to diagnose, antemortem neoplastic cardiac encasement with constriction can be suspected by (a) clinical and hemodynamic parameters consistent with pericardial constriction, (b) unusually promi-

nent cardiac impulses and heart sounds, and (c) inability to obtain pericardial fluid by standard aspiration technique. The massive tumor involvement encasing the heart and producing a weight of greater than 1500 grams, the largest in our review of metastatic cardiac tumors, also makes this case unusual compared to the majority of previously reported metastatic neoplasms to the heart.

SUMMARY

A case of massive cardiac constriction due to metastatic carcinoma with obliteration of the pericardial sac from a clinically silent primary adenocarcinoma of the lung is presented. There was massive cardiac enlargement and an apparently large pericardial effusion by right heart catheterization. Loud crisp heart sounds with prominent cardiac impulses and inability to obtain pericardial fluid by aspiration suggested pericardial constriction by neoplastic encasement. At autopsy massive tumor involvement encasing the heart and producing a weight of greater than 1500 grams was found.

To our knowledge this is the largest recorded example of metastatic cardiac tumors in the literature. The mechanisms by which malignant neoplasms involving the pericardium can interfere with normal cardiac function are discussed. Diagnostic clues in compressive pericardial disease due to neoplasm are described. The hemodynamic and echocardiographic findings of pericardial constriction are reviewed.

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Calcification as a Complication of Hyperalimentation*

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Intravenous infusions of calcium salts have been used therapeutically for a variety of medical conditions. To reduce the risk of calcium extravasation into the soft tissue in neonatal infants, it is recommended that calcium should be mixed and diluted with the hyperalimentation solution which is prepared daily.

Calcium infusions for treatment of neonatal hypocalcemia have been reported to cause soft tissue changes and calcification.[1] The purpose of this article is to report two infants who developed extensive soft tissue calcification after receiving calcium gluconate via peripheral hyperalimentation by the intravenous push method.

CASE REPORTS

Case #1—A female was born after 39 weeks gestation by normal spontaneous delivery with a birth weight of 3100 gms., and Apgar score of 9 and 9 at 1 and 5 minutes. Examination showed evisceration of the small and large intestines from the right side of the umbilicus; the rest of the examination was unremarkable. The gastroschisis was surgically corrected a few hours after birth. Peripheral hyperalimentation was initiated on the second day of life and was continued for seventeen days. Calcium gluconate (200 mg/kg/day) as ten percent solution was administered every eight hours by slow intravenous bolus injection. At three weeks of age the patient was noted to have extensive areas of circumscribed non-tender subcutaneous hardening at the ventral aspect of the right forearm and medial aspect of the left lower leg. Radiographs of the involved extremities (Figure) showed calcification of the subcutaneous tissues. Physiotherapy was instituted and two weeks later there was marked softening of the involved tissues.

Case #2—A 1162 gram-male was delivered after 28 weeks gestation by cesarean-section because of placenta previa. He

Figure—Roentgenogram taken at three weeks shows extensive soft tissue calcification of right forearm.

*This study is from the Division of the Newborn, Department of Pediatrics, Jersey City Medical Center. Correspondence may be addressed to Dr. Al-Salihi at the Medical Center, 50 Baldwin Avenue, Jersey City, NJ 07304.

> " . . . [calcium] extravasation can occur without being recognized; . . .

> " . . . soft tissue injury caused by calcium extravasation is directly related to the concentration of free calcium ions . . . "

was admitted to the neonatal intensive care unit and received blood transfusion because of hypovolemic shock. The infant also was treated for mild respiratory distress. On the second day of life, the infant was placed on peripheral hyperalimentation therapy and received calcium gulconate (200 mg/kg/day) as 10 percent solution by slow intravenous bolus injection every eight hours. Hyperalimentation was continued through the first 34 days of life. At the fourth week of age physical examination of the infant revealed hard circumscribed nontender areas over the lower third of the right leg. Radiographs of the involved extremity reveal diffuse calcification of the soft tissue. Physiotherapy was instituted and after two weeks the affected area of the leg became much softer and the leg decreased in size. The baby was discharged from the hospital in satisfactory condition on the 79th day of life.

DISCUSSION

The two infants described received calcium gluconate by intravenous injection but without clinical signs of extravasation. Soft tissue changes became evident several weeks after the infusion, as has been reported in the literature.[2,3]

Tyrala[4] stated that the intravenous push (bolus injection) method of calcium administration with frequent checks of the intravenous line has the advantage of significantly decreasing the incidence of calcium extravasation. However, as was seen in our patients and those reported in literature, [calcium] extravasation can occur without being recognized; the needle or catheter may be in position but the solution still may leak since increased pressure is applied to the line when pushing the fluid.

Heckler and McCraw observed that the soft tissue injury caused by calcium extravasation is directly related to the concentration of free calcium ions (Ca^{++})[2]; Roberts stated that the complications related to calcium extravasation appear to be dose related.[3]

Because of these findings and, as a result of our clinical experience, we suggest:

(1) Lowering the concentration and the dose of calcium that accidentally may be extravasated at a particular time if the push method is used.

(2) The total daily requirement of calcium should be diluted with the total daily hyperalimentation preparation and given by continuous flow. The continuous flow administration of calcium as a method of choice is supported by Robert[3].

SUMMARY

Soft tissue injury may become evident several weeks after calcium intravenous infusion by push method. Two cases are presented with this complication. To reduce the risk of extravasation of calcium into the soft tissue the following is recommended:

1. Frequent observation of the intravenous lines.
2. In neonates the calcium should be mixed and diluted with the daily prepared hyperalimentation rather than being given by intravenous push method.

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Failure of Cimetidine Prophylaxis in the Critically Ill Patient: Two Fatal Cases of Duodenal Perforation

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Prophylactic cimetidine therapy has been shown to be effective in preventing gastrointestinal ulceration in the critically ill patient. We report two cases in which acute duodenal ulcers formed and perforated despite cimetidine prophylaxis. Gastric pH monitoring is advocated to assess adequacy of treatment.

Acute gastrointestinal ulceration, which frequently is found in critically ill patients, requires the presence of acid to develop. Controlled studies have shown that neutralization with antacids protects against ulceration. Cimetidine, a specific competitive histamine H-2 receptor antagonist, has been shown to be an effective inhibitor of both basal and meal-stimulated gastric acid secretion in animals and man.[1] Thus, in the severely ill patient with respiratory, hepatic, cardiac or renal failure, sepsis, peritonitis, burns, or trauma including head and spinal cord injuries, prophylactic administration of antacids or cimetidine has been recommended to protect against ulceration.[2,3]

We report our experience with two severely ill patients in whom acute gastrointestinal ulceration with perforation occurred despite cimetidine prophylaxis.

CASE REPORTS

Case #1—A twenty-six-year-old male was admitted to the Georgetown University Surgical Division, D.C. General Hospital following a gunshot wound to the left neck. There was no history of gastrointestinal ulceration. Initial evaluation revealed quadriplegia. An endotracheal tube was inserted and intravenous fluids were administered. The entrance wound, which was located along the anterior border of the left sternocleidomastoid muscle midway between the sternal notch and the mastoid process, was draining mucous. The carotid pulsation was intact. X-rays of the chest and skull were normal. Cervical spine x-rays revealed fragmentation of the fourth cervical spine vertebra. Cefazolin (Ancef®) was administered preoperatively.

Surgical exploration of the neck revealed no injury to the major vascular structures. An entrance wound at the body of the fourth cervical vertebra was noted. A tear in the cervical esophagus was debrided and closed in two layers and a tube gastrostomy was performed. Treatment with cimetidine (Tagamet®) in dose of 300 mg. every six hours intravenously was started. A tracheostomy was performed after the neck exploration.

Gastrointestinal function returned and liquid feedings, which were administered via the gastrostomy tube, were tolerated. On the ninth postoperative day, the patient's condition suddenly deteriorated and he suffered a cardiac arrest. He was resuscitated quickly, but he remained unresponsive to verbal and painful stimuli. His pupils were fixed and dilated. Abdominal examination was unremarkable except for the absence of bowel sounds. No free air was seen on cross table lateral abdominal x-rays. Clindamycin (Cleocin®), ampicillin and gentamicin (Garamycin®) were administered for suspected gram negative sepsis.

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". . . when cimetidine prophylaxis is used in the severely stressed patient, gastric pH should be monitored to assess adequacy of treatment."

". . . the pH should be kept above three at all times for adequate prophylaxis against stress ulcerations."

The patient suffered a second cardiac arrest on the following day; he did not respond to treatment. Autopsy revealed a large ulcer which had perforated the lateral posterior wall of the duodenum.

Case #2—A fifty-year-old female, who was mentally obtunded, was transferred to the neurosurgical service at Georgetown University Hospital following a suspected acute cerebrovascular hemorrhage. Emergency arteriography revealed a leaking Berry aneurysm. There was no history of gastrointestinal ulceration. Prophylactic administration of cimetidine (Tagamet®) in dose of 300 mg. intravenously every six hours was begun on the day of admission. On the evening of the second hospital day, she suddenly became hypotensive, febrile, tachycardic and oliguric. Intravenous fluid was administered and a general surgical consultation was obtained. The abdomen was distended slightly and quiet. Palpation did not elicit any patient response. An x-ray of the abdomen revealed intraperitoneal fluid but no free air. Abdominocentesis revealed bile-stained fluid.

An emergency laparotomy was performed under local anesthesia. Two liters of bile-stained peritoneal fluid were evacuated and an anterior duodenal perforation was identified and oversewn. A gastrostomy tube was inserted. Postoperatively, gentamicin (Garamycin®), and clindamycin (Cleocin®) were administered. Cimetidine was continued postoperatively. There was gradual return of gastrointestinal function, and her mental status improved slightly.

On the tenth postoperative day, the patient suddenly became hypotensive and passed 300 cc. of clotted blood per rectum. Intravenous crytalloid solutions and blood were administered, but non-responsive cardiac arrest developed.

Autopsy revealed a posterior duodenal ulcer separate from the previous ulceration which had been closed.

DISCUSSION

Prophylactic cimetidine therapy has been shown to prevent gastrointestinal ulceration in critically ill patients. However, our two patients, who were treated prophylactically with cimetidine, perforated a duodenal ulcer. The second patient also bled post-operatively from a second duodenal ulcer while still on cimetidine prophylaxis.

There have been reports of ulcer perforations in patients receiving cimetidine but it was felt that those ulcers were chronic in nature.[4,5] In both cases presented here, no previous ulcer history was documented. This experience leads us to believe that when cimetidine prophylaxis is used in the severely stressed patient, gastric pH should be monitored to assess adequacy of treatment.

Hastings *et al.* have described a method of gastric pH monitoring combined with antacid titration.[6] The pH of the stomach is measured with pH paper hourly via a naso-gastric tube and 30 to 60 cc. of antacid is introduced according to the pH. It is felt by numerous authors that the pH should be kept above three at all times for adequate prophylaxis against stress ulcerations.

A recent paper by Priebe *et al.* showed by pH monitoring that cimetidine alone is less effective than antacids in providing adequate prophylaxis against acute gastrointestinal bleeding.[7] Dosages of cimetidine as high as 400 mg. intravenously every four hours were administered.

Dunn *et al.* have recommended cimetidine to prevent the development of gastric mucosal stress bleeding and for the initial treatment of hemorrhagic gastritis.[8] However, the pH was not monitored in this study.

In cases where the pH indicates that cimetidine is not adequate, and antacid can be added, it should be administered to assure that gastric acidity is reduced. Close pH monitoring therefore may lessen the risk of unrecognized ulcerations and allow the physician to assure better protection.

SUMMARY

Cimetidine administration has been advocated as a prophylactic measure to avoid gastrointestinal ulceration. We have presented two critically ill patients who developed fatal duodenal ulcer perforation despite cimetidine prophylaxis. Frequent gastric pH monitoring is recommended to assess the adequacy of cimetidine prophylaxis.

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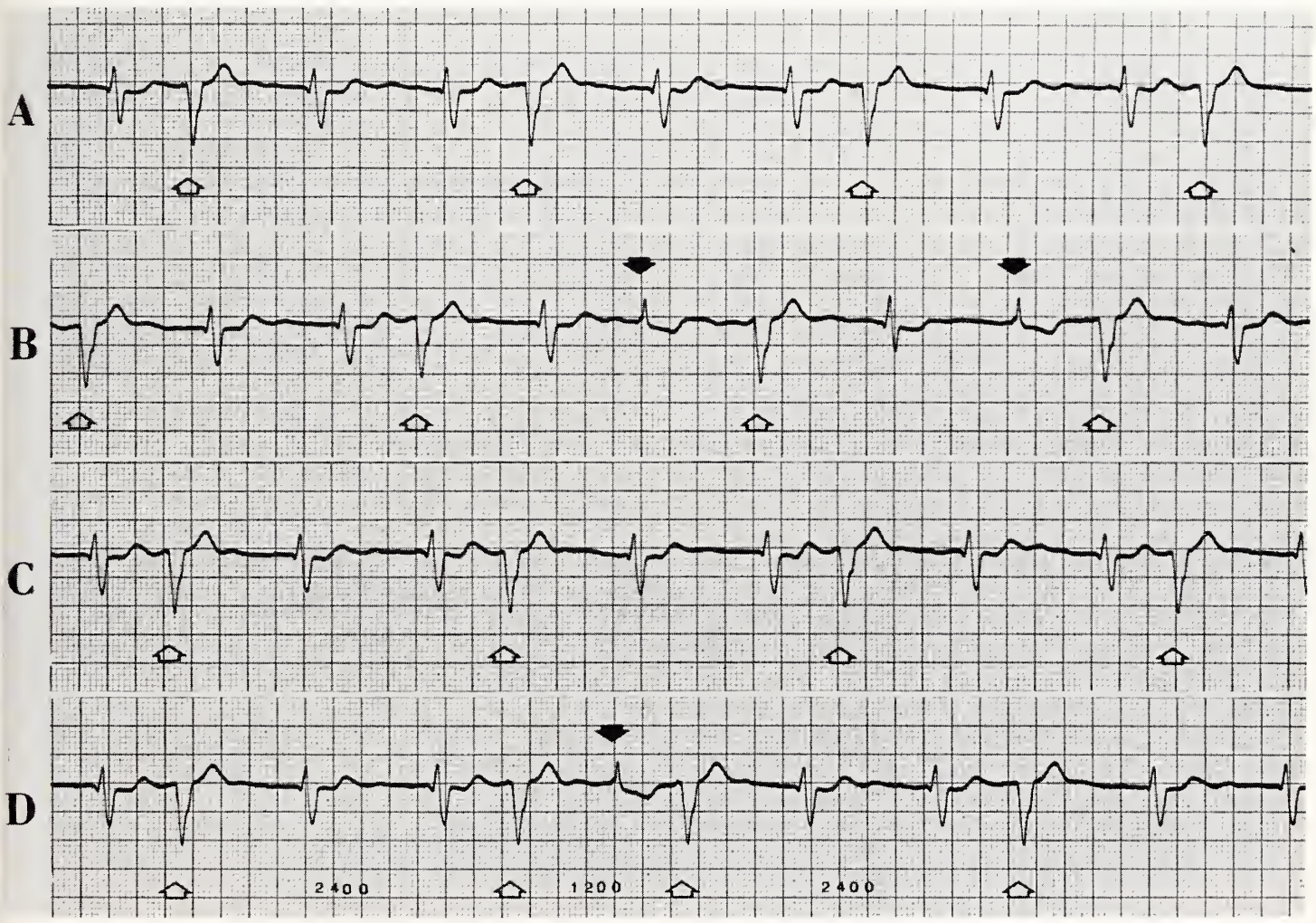
Fixed Coupling in Ventricular Parasystole: a Result of Digitalis Toxicity

SHASHI K. AGARWAL, M.D., Albuquerque, NM*



The electrocardiographic strips (Lead II) were recorded from an 85-year-old female admitted to Holy Name Hospital with congestive cardiac failure. Laboratory results included a serum potassium of 4.6 Meq/L, blood urea nitrogen of 28 mg/dl and a serum digoxin level of 2.4 ng/ml.

INTERPRETATION OF THE ELECTROCARDIOGRAM

Strip A reveals atrial fibrillation with complete atrioventricular block. There is an accelerated idioventricular rhythm at a rate of 64 per minute. Interspersed are numerous ventricular complexes with a different configuration (open arrows) bearing fixed coupling intervals to the immediately preceding QRS complexes and occurring in a trigeminy pattern. These findings are consistent with digitalis toxicity. Strips B and C, which are continuous, exhibit occasional supraventricular captures (solid arrows). These complexes, which do not demonstrate any conduction disturbance, fail to interrupt the trigeminal sequence. Interestingly, the coupling intervals of the ventricular complexes following these beats (open arrows) change in order to maintain interectopic interval constancy, raising the suspicion of ventricular parasystole. The diagnosis is confirmed in Strip D, where a ventricular parasystole at a rate of 50 per minute is obvious.

*When this report was prepared Dr. Agarwal was a Fellow in Cardiology at St. Michael's Medical Center in Newark. He may be addressed now at the University of New Mexico Hospital, 2211 Lomas Blvd, NE, Albuquerque, NM 87106.

DISCUSSION

Ventricular parasystole, the most common of all parasystolic rhythms, is a dual rhythm characterized by an ectopic ventricular pacemaker demonstrating a unique unidirectional conduction block, situated within it or its immediate vicinity and protecting it during all phases of its cycle.[1] This focus fires independently and competes with the dominant rhythm of the heart. Since, unlike nonparasystolic extrasystolic rhythms, its activity is not contingent on the basic rhythm, no constancy of relationship between the two is seen and the resultant variable coupling is one of the diagnostic hallmarks of this dysrhythmia.[2] Further, as it presumably fires at a constant rate and escapes the potential resetting properties of the basic rhythm, the intervals between its complexes are always constant or bear a simple numerical relationship to one another. This interectopic interval multiplicity results from the occasional inability of the parasystolic impulse to capture the myocardium, either due to residual refractoriness from the previous depolarization or due to a perifocus exit block of uncertain nature.

The occurrence of ventricular parasystole with fixed coupling intervals has been recognized.[3] As the ventricular parasystolic and sinus pacemakers are invariably mutually protected, a fortuitous numerical rate relationship between the two may manifest as fixed coupling of the parasystolic complexes.[4] Retrograde ventriculo-atrial conduction of the parasystolic beats will reset the sinus node causing reversed coupling and thus will present in a similar fashion, unless sinus parasystole coexists.[3] The sinus rhythm also may exhibit a constant reversed coupling as a result of entrainment, whereby the extrasystole-induced blood pressure alterations influence neuronal activity of the baroreceptor reflex arc and lead to modulation of sinus node frequency.[5] An apparent fixed coupling between the two rhythms may appear if the parasystolic rhythm is fast and dominant, without any actual inter-relationship. [6] Rarely, the ventricular parasystole becomes dependant on the supraventricular rhythm, its activity manifesting only as a result of reentrant excitation[7] or due to conduction of its subthreshold discharges during the supernormal phase of the previous beat.[8]

The illustrated electrocardiographic phenomenon presents another cause of fixed coupling in ventricular parasystole, viz., digitalis-induced complete atrioventricular block. Since the idioventricular escape focus is unprotected and lies in the same biventricular chamber as the parasystolic pacemaker, reversed coupling of the former due to resetting by the latter takes place, resulting in a constant affiliation between the two rhythms. The rhythm alteration following occasional supraventricular captures (as happens in my patient) or the occurrence of ectopic beats from other ventricular foci will be the only diagnostic clues. The parasystolic rhythm persisted in spite of correction of the digitalis excess.

SUMMARY

An uncommon manifestation of digitalis toxicity, namely, induction of fixed coupling in ventricular parasystole, is presented. Other recognized causes of a similar deviation are briefly reviewed.

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Bergen County's Poet-Physicians

MICHAEL A. NEVINS, M.D., Paramus

Throughout history many physicians have distinguished themselves as literary figures; the list includes Rabelais, Tobias Smollet, Oliver Goldsmith, John Keats, Oliver Wendell Holmes, Arthur Conan Doyle, A.J. Cronin, Anton Chekhov, Robert Bridges and Somerset Maugham. Bergen County has shared in this rich tradition and my paper will consider four of our prominent poet-physicians: Thomas Dunn English, Ralph S. Cone, William Carlos Williams, Martin C. Rosner.

THOMAS DUNN ENGLISH, M.D.

One of the most celebrated and colorful characters in the pantheon of Bergen County physicians was Thomas Dunn English who practiced in Fort Lee before the Civil War. English was born near Philadelphia in 1819, working at various times as a doctor, lawyer, journalist, editor, playwright, historian, author of six novels and weigher for the Port of New York!

As a Fort Lee physician in the 1850s he traveled without any conveyance, sometimes walking ten miles to visit his patients. Dr. English was an inveterate tobacco chewer who had a kindly and jovial disposition and a casual philosophy about money. It was alleged that he "never paid a bill nor did he send any" and, since he rarely attempted collection of fees, he was always very poor. English received his medical degree from the University of Pennsylvania in 1839, then studied law and was admitted to the bar in 1842. He claimed that his grandmother was an Indian squaw and for this reason it was said that he was truly "doctor, lawyer, and Indian chief."

English's literary claim to fame was the ballad *Ben Bolt* published in 1843 at the request of the editor of the *New York Mirror*. Newspapers throughout the world copied *Ben Bolt* and it attained phenomenal popularity during the Civil War period, being a favorite of soldiers on both sides. The Library of Congress lists 26 different versions of the song. Typically, Dr. English never received a penny for his work and in time came to resent its great popularity. At a meeting of the Essex County Medical Society he threatened to walk out when a quartet appeared to sing *Ben Bolt* in his honor. He considered the song "one of my early indiscretions."

Ben Bolt

Don't you remember sweet Alice, Ben Bolt—
  Sweet Alice whose hair was so brown,
Who wept with delight when you gave her a smile,
  And trembled with fear at your frown?
In the old churchyard in the valley, Ben Bolt,
  In a corner obscure and alone,
They have fitted a slab of granite so gray,
  And Alice lies under the stone.

There is change in the things I loved, Ben Bolt,
  They have changed from the old to the new;
But I feel in the deeps of my spirit the truth,
  There never was change in you.
Twelve months twenty have past, Ben Bolt,
  Since first we were friends—yet I hail
Your presence a blessing, your friendship a truth,
  Ben Bolt of the Salt-sea gale.

*Dr. Nevins, an internist-cardiologist from Woodcliff Lake, is Co-director of Medical Education both at Bergen Pines County Hospital, Paramus, and Pascack Valley Hospital, Westwood. He is Co-editor of *The Bergen Pines Medical Staff Report*, is a frequent contributor to the medical literature and last year published a book, *Early Physicians of Northeastern Bergen County*. He may be addressed at Bergen Pines County Hospital, Paramus 07652.

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DOCTORS' NOTEBOOK

Trustees' Minutes September 21, 1980

A regular meeting of the Board of Trustees was held on Sunday, September 21, 1980, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Membership . . . Noted that as of August 31, 1980, MSNJ membership was 8,486, 891 of whom are dues-exempt; AMA membership from New Jersey is 5,291. This is an increase of 165 paid MSNJ members and 77 AMA members since June 30. It was directed that the matter of the increasing number in the dues-exempt category be referred to the Committee on Long Range Planning and Development.

. . . Approved the following recommendation and noted that results of the membership surveys of the ASAE and AMA reveal that the decision to join organized medicine at both the state and national levels was not based on the services available through membership.

That the final report of the survey of the Medical Society of New Jersey membership be referred to the Committee on Long Range Planning and Development for consideration and report to the Board before the end of the year.

Litigation Update . . . Noted the following concerning MSNJ litigation:

a. **Rule 4:21—Supreme Court Subpanels**—The determination of the Appellate Division to remove from the 4:21 panels any physician who has an active suit against him is being appealed to the State Supreme Court and will be heard during the Fall term. Panel hearings still are being held, however.

b. **State Board of Medical Examiners vs. Driggs**—Litigation involving the ruling for revocation of licensure for the physician involved and penalties remains active and still has to be heard by the Appellate Division; chances for reversal of the ruling appear good.

c. **Livingston vs. MSP, MSNJ, et al.**—Litigation in this case was dismissed by the Court and costs were awarded to the Society; efforts will be continued to collect the monies awarded, although the plaintiff is no longer in New Jersey.

d. **MSNJ et al. vs. State Board of Medical Examiners** (Radiology Services)—Concerning ligitation in opposition to the ruling on provision of mandatory radiological services to chiropractors, the Radiological Society is being asked to reconsider its requested legal direction, which may produce a biased forum, and accept the procedure being suggested; the prospects for success appear good if the case is decided by the Supreme Court on an objective basis.

Nurse/Midwife Regulatory Proposal . . . Voted to oppose the adoption of the proposed regulations of the State Boared of Medical Examiners concerning the registering and regulating of the practice of certified nurse/midwife (Subchapter 9, 13:35-9.1-6) and so to notify the State Board and request a public hearing.

Council on Legislation . . . Noted the Board's recognition of Mrs. O'Hare's ten years of service to MSNJ and asked to join in by extending appreciation for her effort as secretary to the Council.

. . . Approved the following position on A-928 taken by the Council:

A-928 Stockman, et al—An Act prohibiting demands for payment as a condition precedent for completion of insurance forms

Prohibits physicians from demanding payment from a patient for services rendered prior to completion of a medical claim form in connection with an insurance form or plan. **CONDITIONAL APPROVAL,** pending inclusion of the following amendment: The Health Insurance claim must contain an "assignment of benefit" as a condition for the mandatory completion of the insurance form.

. . . Approved a recommendation of the Council that legislation be drafted with appropriate safeguards to insure the physicians' civil rights in the use of State Board of Medical Examiners' decoys in a physician's office.

. . . Approved a recommendation of the Council that the Board of Trustees take whatever steps are necessary, through the State Board of Medical Examiners or the Legislature to broaden the scope of limited certification of x-ray technicians and work out a procedure for granting limited licensure to x-ray technicians who perform limited x-ray work in physicians' offices under the direct supervision of the physician.

. . . Approved the following recommended positions on current bills of medical interest:

S-1179 Skevin—Diethylstilbestrol Related Disorders

Requires the State Department of Health to establish screening programs to locate, diagnose, and refer to proper treatment those who were adversely exposed to DES. The State Deparment of Health is to file a report with the Legislature one year from the enactment of this legislation. **APPROVED**

S-1191 Maressa—Abortion

Permits:

1. First trimester abortions by a physician when:

a) The woman certifies, in writing, as to informed consent which shall contain known possibilities of adverse future events, complications, physical condition of the fetus at the time of abortion.

b) There must be a twenty-four hour waiting period between consent and the procedure.

c) Physicians violating this section are disorderly persons.

2. No abortion may be performed after the first trimester unless:

a) The woman is advised a live born infant may result.

b) The procedure is performed in the hospital.

3. No abortion may be performed on a viable fetus except to preserve maternal life or health.

4. When the fetus is viable, a second physician must be present and the effort must be made to save the life of the aborted fetus.

5. Twenty-four hour parental notification is required for all women under the age of eighteen. If actual notice is not given, then seventy-two hour constructive notice must be given. **ACTIVE OPPOSITION**, because this bill is unnecessary and restrictive since the public health questions of the bill have been resolved through the joint regulations of the Department of Health and the State Board of Medical Examiners in concurrence with the New Jersey Obstetrical and Gynecological Society. The bill violates law established

through United States Supreme Court decisions.

S-1200 Bedell—Contact Lens Dispensing

Creates the profession of contact lens dispensing and fitting for non-physicians and non-optometrists. Licensure and regulation would be through the Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians. A prescription by a licensed optometrist or physician would be required. **ACTIVE OPPOSITION** to that portion of the bill referring to contact lenses, because MSNJ does not feel it would be beneficial to the health of the consumer. Contact lenses improperly used or fitted may cause irreparable damage to the cornea. The fitting of contact lenses should be done by the prescribing ophthalmologist or optometrist.

S-1232 Vreeland—Professional Service Corporations

Amends existing law to allow licensees in certain allied fields to be shareholders in professional service corporations with more broadly licensed individuals, i.e., physicians and dentists. **APPROVED**

S-1293 Feldman—Licensing of Speech Therapists and Audiologists

Creates a direct licensing system within the Division of Consumer Affairs for speech therapists and audiologists. Continuing education is mandated. The individuals so licensed would function independently. Physicians and their employees are exempt under the Act as long as the employee is not termed a "speech therapist or audiologist." **ACTION DEFERRED**, pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

A-1332 Bassano—Marriage Licenses

Requires all female applicants for a marriage license, under 45 years of age, to show laboratory evidence of a rubella response test as a condition precedent to the issuance of a marriage license. The physician is to inform the applicant of the medical significance of the results of the serological test. **ACTION DEFERRED**, pending further information from MSNJ's Council on Public Health and the New Jersey Chapter, American Academy of Pediatrics.

A-1342 Bassano—Determination of (Rh) Factor

Requires physicians to take a blood specimen from women patients prior to delivery or abortion, but no later than twenty-four hours after abortion, delivery, or miscarriage. The blood shall be tested to determine (Rh) Factor and the woman shall be advised of these results. (No penalty proviso is included in the current version of the bill.) **DISAPPROVED,** becasue this procedure is already current practice and this bill would be unnecessary legislation.

A-1345 Bassano—Disposal of Radioactive Waste

Would require specific legislative approval of permanent disposal sites of radioactive materials within New Jersey. **NO ACTION**

A-1439 Weidel—Blood Donations

Provides for a $25 deduction from gross income for each pint of blood a given taxpayer donates to nonprofit blood-collecting organizations. **NO ACTION**

A-1454 Hurley—Withholding or Withdrawing of Life-Sustaining Procedures in Event of Terminal Illness

Empowers adults to execute a statutory form of directive to their physicians providing for the withholding or withdrawing of life sustaining procedures during a terminal illness. The directive would be valid for five years and provides immunity for physicians and other providers complying with such a directive. "Life sustaining" means a modality or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which would serve only to artificially prolong the moment of death where in the judgment of the attending physician death is imminent whether or not such procedures are utilized. It does not include "the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain." **APPROVED**

A-1592 Herman—Abortion

Requires the Department of Health to prepare a booklet which outlines the medical risks of abortion as opposed to childbirth. Further, requires a complete listing of alternative services should the woman choose not to have an abortion. The booklet shall be made available to physicians. Physicians shall make copies available to women seeking abortions and shall respond to questions. The physician must secure an acknowledgement from the patient. (Forms to be provided by the Department of Health.) All health care facilities and physicians engaged in the provision of abortion services shall file reports with the Department of Health within ten days following the performance of abortions. Failure to comply with this Act is a disorderly person's offense and can lead to disciplinary proceeding under N.J.S. 45:9-1 et seq. **ACTIVE OPPOSTION**, because existing statutes and regulations in case law cover the appropriate health concerns of this legislation and constitutional issues would be raised under the format of this bill.

A-1608 Garvin—Reportable Disease

Requires optometrists and ophthalmologists to report confirmed cases of blindness (central visual acuity of 20/200 or less in the better eye) to the State Commission for the Blind and Visually Impaired. **APPROVED**

A-1613 Fortunato—Treatment of Compulsive Gamblers

Requires the Department of Health to establish and advertise a treatment center for compulsive gamblers and to solicit grant funds for the establishment and operation thereof. The Commission shall submit operational and fiscal reports to the Legislature on an annual basis. **ACTION DEFERRED.** The Council agrees with the intent of this legislation, but will await further information from MSNJ's Council on Mental Health before taking a position.

A-1643 Muhler—Prescriptions for Eyeglasses and Contact Lenses

Requires physicians and optometrists to supply patients with written prescriptions for their eyeglasses or contact lenses so that they may seek the dispenser of their "choice." **ACTIVE OPPOSITION,** to that portion of the bill referring to contact lenses, because MSNJ does not feel it would be beneficial to the health of the consumer. Contact lenses improperly used or fitted may cause irreparable damage to the cornea. The fitting of contact lenses should be done by the prescribing opthalmologist or optometrist.

A-1665 Burgio—Rights of Nursing Home Residents

Grants nursing home residents the free choice of physician and the right to purchase medications from the pharmacy of their choice. **ACTION DEFERRED,** pending further information from the New Jersey Health Care Facilities Association. (MSNJ will correspond with the sponsor of the bill to ascertain its exact purpose and procedure.)

A-1710 Herman—Comparative Negligence

Amends the current statute to remove the bar that the plaintiff's negligence must exceed that of any defendant he seeks recovery against. Under this bill, if the aggregated negligence of the defendant exceeded the comparative negligence of the plaintiff, recovery would be permitted against all defendants on a pro rata basis. **NO ACTION**

A-1719 Herman—Selection of Medical Treatment

Permits patients to appoint agents to make decisions regarding medical treatment when the patient is incapable of doing so for himself. The physician is to decide whether the principal is incapable of exercising the judgment necessary to informed consent which would then empower the agent to act on his behalf. **ACTIVE OPPOSITION,** because this bill places on the physician the duty of determining whether a patient is capable of judging the physician's actions and also because current legal procedures for this type of patient function well under court monitoring.

A-1725 Herman—Smoking in Health Care Facilities

Prohibits smoking in all health care facilities except for:

1. Private rooms or rooms where all patients consent to smoking.
2. Waiting rooms or lobby if there is more than one. If not, smoking is permitted as long as there is adequate sectionalization.
3. Cafeteria with a capacity of fifty or more, as long as a nonsmoking section is designated.

Smoking is prohibited in the waiting rooms of private practitioners, unless there is more than one waiting room. **APPROVED**

A-1726 Herman—Smoking

Requires schools, colleges, universities, or professional schools to regulate smoking in their building complexes and to permit smoking only in certain designated areas. **APPROVED**

A-1750 Hardwick—Nursing Homes

Requires the Department of Health to determine factors of precedence for nursing home admission. Nursing homes in conformity with these criteria would then maintain numerical waiting lists. **DISAPPROVED,** because this bill appears to be impractical legislation.

A-1753 Otlowski—Physicians' Assistants

Permits the use of physicians' assistants when the P.A. has a valid registration with the State Board of Medical Examiners, a protocol and job description filed with the Board, and a designated supervising physician who is on the premises at all times. An exception to the last requirement may be granted by the State Board only when the type of service and the instances of provision are precisely defined. **ACTIVE OPPOSITION,** because licensure and/or registration of physicians' assistants will neither contribute to the quality of medical care nor decrease the cost of medical care. (House of Delegates/December 10, 1979)

A-1764 Bornheimer—Dental X-rays

Provides that dental x-rays may be used only for diagnostic and treatment purposes and not to verify performance of dental ser-

vices to health insurers, dental plans, etc. **APPROVED**

AMA Delegation . . . Held for discussion at the October meeting was an item from the report of the Chairman of the New Jersey Delegation to the AMA, James S. Todd, M.D., pertaining to nominations for appointment at the national level and a letter from James H. Spillane, M.D., AMA Alternate Delegate.

Health Care Administration Board . . . Received as informative written reports from Daniel J. O'Regan, M.D., on his attendance at the August 7 and September 4 meetings of the Health Care Administration Board.

State Board of Medical Examiners . . . Received as informative a written report from Anthony P. DeSpirito, M.D., on the July 9 meeting of the Board of Medical Examiners, and from Myles C. Morrison, Jr., M.D., on the August 13 meeting.

. . . Noted that the State Board had reviewed the Society's invitation to send a representative to MSNJ's Board meetings and had decided to leave the invitation open to the discretion of the individual members of the Board of Medical Examiners.

New Jersey Coalition for "21" . . . Approved the following recommendation from the Committee on Drug and Alcohol Abuse, which had been asked to consider a request from the New Jersey Coalition for "21" for financial assistance in this group's attempt to raise the legal drinking age to 21:

That further consideration to raising the legal drinking age should not be made until the results of the recently enacted legislation raising the drinking age to 19 can be reviewed.

Diagnosis Related Groups . . . Approved the following recommendation:

That the Medical Society of New Jersey support the position that the DRG Project, if operative, be monitored by the practicing physicians in the State and that the concepts contained in Resolutions #3 and #23 (E), from the 1980 House of Delegates, be upheld; and that the appropriate state agencies be so informed.

Investigation of Pharmacies . . . Agreed to continue the practice of cooperating with the State Board of Medical Examiners in the investigatory procedures of certain retail pharmacies by supplying the names of physicians willing to provide prescriptions for drugs.

Medicare Reimbursement for Hospital-Based Physicians . . . Noted that the United States District Court for the Eastern District of Arkansas preliminarily enjoined implementation of the Department of Health and Human Services' hospital-based physician notice (which would have disallowed reimbursement, after July 1, 1980, to pathologists for the professional component of clinical pathology services under Part B of Medicare and would have redefined physician services in relation to pathologists), pending the outcome of a lawsuit challenging the Department's action.

Writing of Orders and Prescriptions by Medical Students . . Noted that the State Board of Medical Examiners has reaffirmed its previous position of opposition to the writing of orders and prescriptions by medical students and determined that there was no current legislative authority that would permit medical students to write such orders, as only interns and residents are exempt from the licensing provision of the statutes in accordance with 45:9-21(D).

Perinatal Designations . . . Adopted a recommendation that the Board of Trustees notify the Governor, the Commissioner of Health and the State Legislature that the Medical Society of New Jersey is opposed to the current perinatal plan and urges that it be suspended until a meeting can be held with representatives of the New Jersey Chapter of the American Academy of Pediatrics to resolve the attendant differences in the State Perinatal Plan approved by the Commissioner, but which differed from that recommended by the Statewide Health Coordinating Council.

Epidemiologic Studies of Cancer in New Jersey . . . Concurred with the opinion rendered by the Attorney General's office that the New Jersey State Department of Health is empowered to inspect pathology records maintained by health care facilities to verify the accurate reporting of cancer cases and that such inspection of medical records, including the incidental inspection of non-cancer patient records, does not violate the personal privacy rights of the patients.

Note: The Department of Health has been engaged in two cancer studies, one involving descriptive epidemiology of cancer in the state and the other retrospective case-control studies of cancers of several anatomic sites. The New Jersey Society of Pathologists had requested an opinion as to the confidentiality of patient records.

. . . Noted that the Department of Health plans a retrospective case-control study of lung cancer and will be contacting members of the Society, and directed that a notice of this study be called to the attention of the members through the *Membership Newsletter* and *The Journal.*

How To Complain to The National News Council*

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*Reprinted from *Columbia Journalism Review*, July/August 1980.

CMDNJ Notes*

Stanley S. Bergen, Jr., M.D.
President

On June 16, a surgical team at CMDNJ-College Hospital, Newark, made medical history with their breakthrough surgery on a 16-year-old Newark girl who had an abnormally large aneurysm in the center of her brain. Headed by Roger W. Countee, M.D., neurosurgeon who is associate professor of surgery at the CMDNJ-New Jersey Medical School, the surgical team included Paul W. Bolanowski, M.D., thoracic surgeon and associate professor, Wen-Hsien Wu, M.D., chairman of anesthesiology at the school, and Otakar R. Hubschmann, M.D., neurosurgeon who is also assistant professor of surgery at the school.

A COMMUNION FOR THE BRAIN

The pineal gland and its adjacent neural structures have been a focus of fascination for anatomists, physiologists, physicians and philosophers since the time of the ancient Greeks who believed this region to be the "Seat of the Soul." However, in spite of the tremendous attention this region has received from several quarters of the medical community, it has remained for the neurosurgeon essentially a "No Man's Land."

Because of its strategic location in what is essentially the geometric center of the cerebral hemisphere, surgical access to lesions in this region has been gained most often only at the expense of intentionally sacrificing important neural and vascular structures. Even then the mortality rate of the operation has been prohibitive, and ravaged survivors of the operation and their families have frequently looked upon death as a more merciful outcome.

Consequently, we are elated by our recent success at the CMDNJ-College Hospital with the surgical cure of a massive vascular anomaly of this region in a teenage girl who now has returned to a normal lifestyle with a normal life expectancy.

Our patient had a congenital arteriovenous fistula of the pineal region that pumped arterial blood into the adjacent great vein of Galen which had ballooned into the size of an orange. Although intractable seizures and incapacitating headaches were the presenting complaints, lethal rupture of the giant thin-walled aneurysm was the imminent consequence.

In spite of improved access to this region which now is afforded by advances in micro-neurosurgical techniques, the problem of controlling potentially torrential hemorrhage from the orange-sized sac of blood, through a dime-sized surgical exposure, six inches below the surface of the brain, has remained the formidable problem which accounts for the continued high failure rate of operation on these lesions. This risk of uncontrollable hemorrhage during the actual operative manipulation of the aneurysm was circumvented by inducing complete circulatory arrest by open-chest cardiac fibrillation for 90 seconds.

Although this afforded the neurosurgeons the luxury of a reversible "cadaver-like" operative field, deep hypothermia and its potential manifold problems, including the inability to quickly restart effective cardiac action, posed even greater challenges to the anesthesiologists and the cardiac surgeons who were not allowed to use heart-lung bypass and anticoagulant drugs.

While there have been several neurosurgical operations which have combined hypothermia and elective cardiac arrest, they had not been tried before for aneurysms in the center of the brain. Moreover, because of the multiplicity of problems previously encountered with such techniques, as well as the additional risks and morbidity experienced with these combined procedures, they have, for obvious reasons, not gained great popularity.

By studying the experiences of others, and the pitfalls which they encountered, we were able to anticipate the majority of potential problems and devise several alternative plans and techniques for coping with each one in advance. That our patient was discharged to her home neurologically intact on the seventh postoperative day is testimony, we believe, to the acceptable morbidity of our newly modified techniques. We believe that our experiences open new horizons for the surgery of similarly curable lesions in this region of the brain which typically afflict children who rarely live to young adulthood.

Although we attribute the success of our surgery to the technological advances in multiple disciplines, e.g., neuro-radiology, micro-neurosurgery, anesthesiology, cardiac surgery and others, which have been made available to us at the CMDNJ-College Hospital, we recognize that the most important parameter of success—this teenager's social reentry into a normal life style—has resulted from the skills and efforts of the myriad of support services and personnel which all have communed with us to make this feat possible.

*Guest columnist this month is Roger Countee, M.D., Associate Professor of Surgery, CMDNJ, New Jersey Medical School.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

The House of Delegates of the American Medical Association, at its July 1980 meeting, approved a report on Health Maintenance Organizations and recommended further study of the concept. The report[1] was prepared by the AMA Council on Medical Services, as directed by the 1978 House of Delegates. That action resulted from the report of the AMA Commission on the Cost of Medical Care.[2]

The report submitted last July contained the following recommendations:

1. That approval of the concept of neutral public policy and fair market competition among all systems of health care delivery continue to be AMA policy, with the potential growth of HMOs being determined not by federal subsidy, preferential federal regulations and federal advertising promotion, but by the number of people who prefer this mode of delivery;
2. That the AMA continue to recognize that no single pattern of health care delivery is necessarily suited to all patients or to all physicians, and that the presence of multiple alternative delivery systems will enable both patients and physicians to exercise true choice;
3. That the AMA continue to express its concern that high standards of quality, adequate physician-patient ratios, and continuity of personal care be maintained in all modes and systems of health care delivery;
4. That individual physicians and groups of physicians become better informed about the pros and cons of establishing or participating in an HMO if interest in this form of health care delivery is present in their community;
5. That the AMA continue to provide information to medical societies and

physicians concerning HMOs;
6. That the AMA encourage research in those areas of HMO performance which have been identified as needing further study; for example whether factors leading to apparent HMO cost-effectiveness are unique to the HMO pattern or whether they may be applicable to other forms of practice.

These are not unlike the recommendations of the MSNJ Task Force on IPA/HMO which were approved by the 1979 House of Delegates of MSNJ.[3]

- That the Medical Society of New Jersey provide educational services to physicians on the status and future of prepaid health care programs.
- That MSNJ assist in the formation of a voluntary organization of IPAs.
- That MSNJ continue to study the progress of existing HMOs, consult with experts on prepaid health care, and be aware of the efforts of government, industry and labor in this regard.
- That the performance and effectiveness of operating HMOs in New Jersey be the subject of continuing study and scrutiny.
- That the quality of care of HMOs should be examined in order to protect the HMO subscriber and the professional integrity of IPA physician members.
- That the need for legal and/or administrative assistance to IPA member physicians should be discussed and evaluated, to determine if this service could be provided through an association of IPAs or some other source.

The recent experience of the Crossroads Health Plan in Essex County has appeared in the press.[4] This plan was the fastest growing IPA in the country not too long ago. Instead of a projected enrollment of 17,000 subscribers by midsummer 1980, there were actually 28,000. While this indicates considerable interest on the part of employers and individuals in the service area, it also shows a need to keep up with the management of utilization of services to a quickly-expanding clientele. Recent alterations in the operation of the Crossroads Plan are expected to correct the situation, and the expectation is that the operation will remain viable. Whether this turns out to be the case or not, it demonstrates the need for careful and current information on the operations of an IPA and HMO. It is a form of small business, and the HMO segment must be operated as a small insurance company. The pace of the marketing operation must not outstrip the capability of the delivery providers. There must be utilization control; there also must be a prompt payment mechanism to the physician participants. The premium structure and the fee schedules must be realistic, and the whole picture needs to be reviewed periodically, to keep one part of the system from overloading the rest. A good management information system is essential, plus someone with responsibility to review the information in a timely manner.

Osman Hull, M.D., President of the American Association of Foundations for Medical Care, has long experience in the operation of prepaid delivery systems. He has prepared a list of observations which he calls "How to fail in the IPA/HMO business without even trying." The list includes the following:
1. Have a small cadre of well-informed, dedicated and highly motivated physicians promote the idea of IPA/HMO.
2. Sell the rest of your colleagues on the idea by assuring them that it will be "business as usual."
3. Distribute all available monies, so that there are no reserves to draw on during high utilization months.
4. Have a mangement information system that doesn't give you timely data, and learn how *not* to use the data even if it is timely.
5. Have a claims payment system that runs two to three months behind.
6. Have a utilization review program that is soft on questionable utilization patterns by both patients and physicians.

Dr. Hull has other observations, but the above should make his point clear. There also could be a list of commandments for marketing personnel.

The IPA concept of delivery of medical care requires close attention by the medical community at large as well as by those physicians who are participating in such a program. It is not a comfortable mode of practice for all physicians nor for all patients. The pressures of the government, of labor and of many segments of industry continue to make it necessary for you and your colleagues to keep informed. The continuing development of the closed-panel HMOs also offers a stimulus for physicians whose patients may be considering joining such a plan.

[1]Health Maintenance Organizations. Report of Council on Medical Services, American Medical Association, July, 1980.
[2]National Commission on the Cost of Medical Care, 1976-1977, AMA.
[3]House of Delegates Special Session, November 18, 1979. Task Force on IPA Project. *J Med Soc NJ* 77:59, 1980.
[4]Health plan is forced to suspend payments. *Newark Star Ledger*, September 8, 1980.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Eric J. Schenkel, M.D., Park Drive Manor, Apt. A-1212, Philadelphia, PA 19144. Einstein 1976. Also, general internal medicine. Board certified (IM). Group, partnership, academic. Available August 1981.

ANESTHESIOLOGY—Peter J. Arches, M.D., 150 Fayette Avenue, Apt. 2-H, Staten Island, NY 10305. University of East (Philippines) 1969. Board eligible. Group practice. Available.

CARDIOLOGY—James Liguori, M.D., 417 Union Avenue, Scotch Plains, NJ 07076. CMDNJ 1976. Board certified. Trained in all invasive and non-invasive techniques. Group, partnership, solo. Available July 1981.

Sheldon Eisenberg, M.D., 300 Community Drive, Manhasset, NY 11030. Cornell 1976. Also general internal medicine. Board certified (IM). Non-invasive techniques, hospital based, or single or multi-specialty group. Available July 1981.

Richard J. Butcher, M.D., Geisinger Medical Center, Danville, PA 17822. University of Pennsylvania 1973. Board certified (IM). Group or partnership. Available July 1981.

DERMATOLOGY—Elliot C. Zweig, M.D., 14310 NE 5th Place, North Miami, FL 33161. SUNY-Downstate 1976. Also, general internal medicine. Board certified (IM). Partnership, group, associate. Available July 1981.

FAMILY PRACTICE—Leslie S. Rachlin, M.D., 1580 Four Mile Drive, Williamsport, PA 17701. Pittsburgh 1978. Group, partnership. Available July 1981.

C. Chin, M.D., 1016 Washington Garden Apts., Washington, NJ 07882. SUNY-Stonybrook 1979. Board certified. Part-time clinic, ER or housestaff duty. Available.

Mark Scheier, M.D., 24 Paerdegat Third Street, Brooklyn, NY 11236. Guadalajara (Mexico) 1977. Board eligible. Group, partnership, multi-specialty group. Available July 1981.

Winthrop C. Dillaway, III, M.D., 322 W. 57th Street, Apt. 45-L, New York, NY 10019. Guadalajara (Mexico) 1975. Board certified. Solo (home office). Available.

GASTROENTEROLOGY—Abbasi Akhtar, M.D., 333 East Ontario Street, Apt. 1512-B Chicago, IL 60611. Liaquat (Pakistan) 1966. Also, general internal medicine and pediatric gastroenterology. Board eligible. Any type practice. Available.

GENERAL PRACTICE—Kirit D. Trivedi, M.D., 546 West Ridgeway Street, War-

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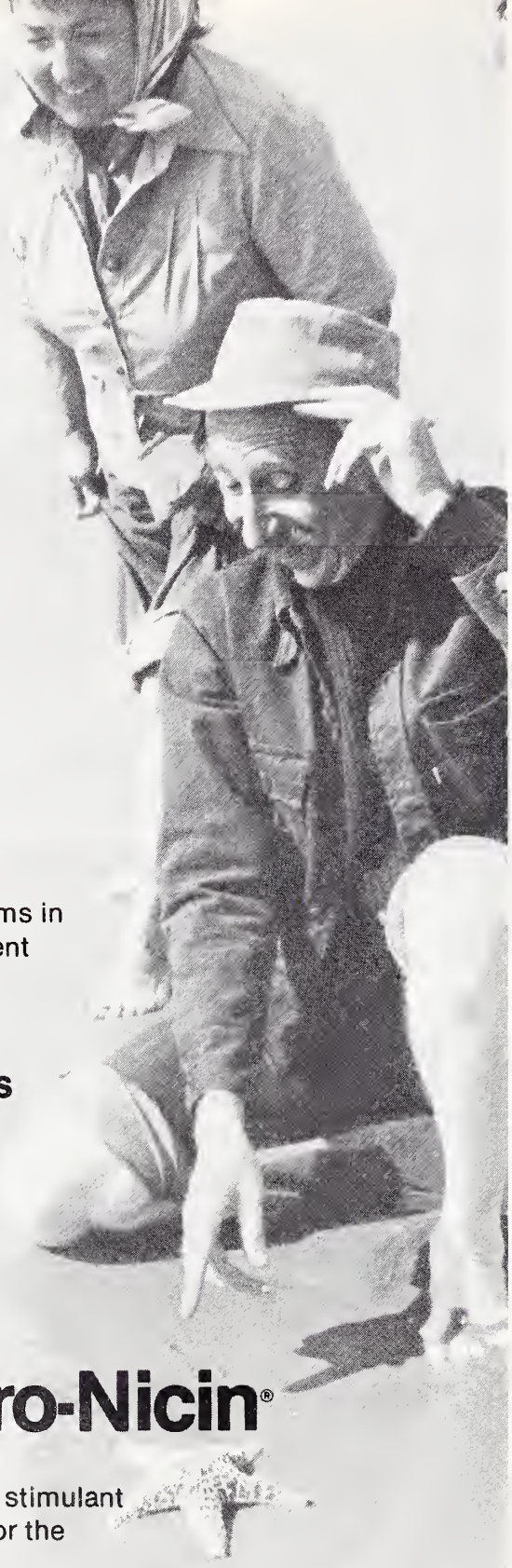

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renton, NC 27589. Baroda (India) 1967. Board certified. Partnership or group. Available June 1981.

Martin L. Schlein, M.D., 106 Merrifield Court, Greenville, SC 29615. Tel Aviv (Israel) 1973. Group, partnership, solo. Available.

HEMATOLOGY/ONCOLOGY—P.S. Bala, M.D., 882-6 Clifton Court Circle, NE, Atlanta, GA 30329. Calicut (India) 1965. Board eligible. Any type practice. Available.

INFECTIOUS DISEASES—Richard M. Zweig, M.D., 9952 North Kendall Drive, No. 3-M, Miami, FL 33176. SUNY-Downstate 1976. Also, general internal medicine. Board certified (IM). Partnership, group, solo, or hospital-based. Available July 1981.

David Brooks, M.D., P.O. Box 33172, San Diego, CA 92103. Dublin (Ireland) 1962. Also general internal medicine. Available.

INTERNAL MEDICINE—Lamberto M. Arellano, M.D., 45 Rocco Street, B-3, Belleville, NJ 07109. Santo Tomas (Philippines) 1973. Special interest, hematology/oncology. Board certified. Solo or partnership. Available July 1981.

Jacques A. Bataille, M.D., 1808 McDowell Avenue, Sharon Hill, PA 16146. Faculté de Medecine, Haiti. Solo, partnership, group. Available.

David Graber, M.D., 196 Howard Avenue, Passaic, NJ 07055. NYU 1975. Subspecialty, gastroenterology. Board certified. Group or solo. Available July 1981.

Lee A. Frankel, M.D., 63-B Cowperthwaite Street, Danbury, CT 06810. Guadalajara (Mexico) 1977. Board eligible. Solo, partnership, group. Available July 1981.

Brijinder Singh Kochhar, M.D., 8501 Fort Hamilton Parkway, Apt. 2-A, Brooklyn, NY 11209. Patiala (India) 1970. Also, pulmonary medicine. Board certified. Any type practice. Available July 1981.

John R. Kalloz, M.D., 109 Green Street, Danville, PA 17821. Pennsylvania State 1978. Board eligible. Single or multi-specialty group. Available July 1981.

Ramulu Eligeti, M.D., Deborah Heart & Lung Center, Browns Mills, NJ 08015. Osmania (India) 1972. Subspecialty, cardiology. Solo or partnership. Available July 1981.

Ben Praport, M.D., 14 Country Club Lane, Elizabeth, NJ 07208. Israel 1975. Subspecialty, gastroenterology. Board eligible. Any type practice. Available July 1981.

Mohammad Razavr Rahman, M.D., 309 Birchwood Court, North Brunswick, NJ 08902. Dow (Pakistan) 1974. Board eligible. Group, solo, institutional. Available.

M. S. Chakrabarty, M.D., 155 East Godfrey Avenue, Ashbourne Manor, E-506, Philadelphia, PA 19120. Grant Medical (India) 1972. Subspecialty, gastroenterology. Board certified. Solo, partnership, group. Available July 1981.

NEPHROLOGY—Jay I. Stack, M.D., 444 East 86th Street, Apt. 33-B, New York, NY

10028. University of Pennsylvania 1976. Also, general internal medicine. Board certified (IM). Group or partnership (willing to do general internal medicine). Available July 1981.

NEUROLOGY—Krishnababu Chunduri, M.D., 2121 Shore Parkway, Apt. 2-F, Brooklyn, NY 11214. Guntur (India) 1973. Board eligible. Solo or group. Available January 1981.

OBSTETRICS/GYNECOLOGY—T. L. Sharpe, M.D., 8309 SW 107th Avenue, Apt. D, Miami, FL 33173. Miami 1977. Board eligible. Group or partnership. Available July 1981.

ONCOLOGY—Pratima D. Parikh, M.D., 16 Wakeman Street, West Orange, NJ 07052. M.S.U. (India) 1973. Board eligible. Group, partnership, solo. Available.

OPHTHALMOLOGY—Mark Gorovoy, M.D., 1661 Kenwood Avenue, Alexandria, VA 22302. George Washington 1977. Board eligible. Any type practice. Available July 1981.

ORTHOPEDIC SURGERY—Inder J. Singh, M.D., WCMC, #1-C Beachwood Hall, Valhalla, NY 10595 K. G. Medical, Lucknow (India) 1968. Solo or partnership. Available July 1981.

OTOLARYNGOLOGY—Samir M. Geleil, M.D., 94 Amith Street, Apt. 3-F, Brooklyn, NY 11201. Cairo (Egypt) 1965. Board eligible. Solo or group. Available July 1981.

PATHOLOGY—Kung N. Rho, M.D., 5601 Boulevard East, Apt. 22-I, West New York, NJ 07093. Chonnam (Korea) 1959. Both AP/CP. Board eligible. Full or part-time group, institutional, or partnership. Available July 1981.

Kamini P. Vaidya, M.D., 956 Woodland Avenue, Oradell, NJ 07649. M.S.U. (India) 1971. Board certified (both AP and CP). Group, partnership, hospital. Available.

Syed A. Hadi, M.D., 162 N. Heck Hill Road, Saint Paris, OH 43072. Osmania/Gandhi (India) 1963. Board certified (AP), board eligible (CP). Any type practice. Available.

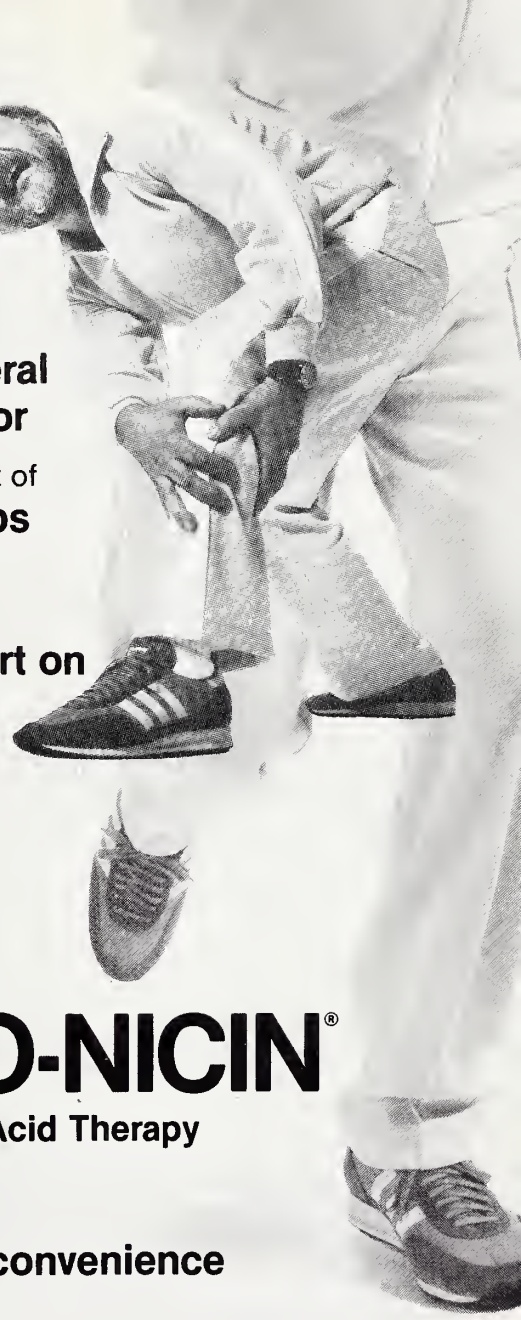
PEDIATRICS—Joseph A. Weinberg, M.D., 29 Atwoodville Lane, Mansfield Center, CT 06250. Harvard 1973. Board certified. Group, partnership, associate. Available.

PSYCHIATRY—Alfredo J. do Pico, M.D., Azcuenaga 1152, Buenos Aires 1115, Argentina. Buenos Aires 1959. Board eligible. Partnership, group. Available.

RHEUMATOLOGY—John Guttell, M.D., 37 Putnam Road, Foxboro, MA 02035. NYU 1976. Board certified. Group or partnership. Available July 1981.

Michael A. Friedman, M.D., 135 Loblolly Lane, Chapel Hill, NC 27514. Wisconsin. Board certified. Group, partnership, solo, hospital-based. Available July 1981.

Thomas A. Giangrasso, M.D., 3550 Jeanne Mance, Apt. 2402, Montreal, Quebec, Canada H2X 3P7. Medical College of PA 1975. Subspecialties, allergy/immunology. Board



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certified (also IM). Any type practice. Available July 1981.

SURGERY, GENERAL—Mohammad A. Jabbar, M.D., 5103 Tiffany Place, 11315 Fondren Road, Houston, TX 77035. Guntur (India) 1966. Also, peripheral vascular surgery. Board certified. Solo, partnership, group (prefer solo). Available July 1981.

R. Nadaraja, M.D., 4B-2 Franklin Apts., Franklin Street, Morristown, NJ 07960. Ceylon 1967. Also, vascular surgery. Board certified. Group, partnership, solo, university. Available.

A. Bassal, M.D., 111 Grove St., #10, West Roxbury, MA 02132. Cairo (Egypt) 1968. Board eligible. Any type practice. Available.

Zahur U. Azhar, M.D., 1684 Central Avenue, Bridgeport, CT 06610. Nishtar (Pakistan) 1963. Board eligible. Solo. Available July 1981.

Dariush Vaziri, M.D., 7510 Brompton Court, Apt. 587, Houston, TX. Tehran (Iran) 1974. Also, vascular surgery. Board eligible. Group, partnership. Available August 1981.

SURGERY, ORTHOPEDIC—Steven H. Fried, M.D., The Hospital for Special Surgery, 535 East 70th Street, New York, NY 10021. Rutgers 1975. Any type practice, plus part-time faculty position. Available July 1981.

SURGERY, VASCULAR—Pramod Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969. Board certified. Solo, group, associate. Available June 1981.

UROLOGY—Vijay S. Athani, M.D., 2009 Trent Court Apartments, Lindenwold, NJ 08021. L.T. Med. College (India) 1970. Board eligible. Solo, partnership. Available.

Elliott Lieberman, M.D., 16-66 Bell Boulevard, Apt. 730, Bayside, NY 11360. SUNY-Downstate 1976. Group or partnership. Available July 1981.

William Kohlberg, M.D., 3450-17A Wayne Avenue, Bronx, NY 10467. Pittsburgh 1975. Board eligible. Group or partnership. Available July 1981.

LETTERS TO THE JOURNAL

Why Not One Professional Association?

July 30, 1980

Dear Dr. Krosnick:

It was very nice of you to write and congratulate me on my appointment. I also appreciate your personal invitation to join the New Jersey Medical Society.

I sincerely ask the question, why do we have three different and equally important professional associations; AMA, APA, etc? Why do we not have one?

(signed Ervin Varga, M.D.
(Carrier Foundation)

August 21, 1980

Dear Dr. Varga:

Dr. Arthur Krosnick referred your recent letter to me for reply. I am very sensitive to the issue you raise as to the need for an AMA, APA, etc. It would indeed be less complicated and probably more effective to have one organization representing physicians.

The AMA as a federation of local societies, it seems to me, is the one organization that adequately can represent physicians on most of the broad issues facing our profession. Through the democratic process beginning at the county and state level, the AMA develops policy representative of its members at all levels. This is as it should be, for it gives strength and hopefully unity to the final actions of the AMA.

Unfortunately, however, the specialist may have legitimate parochial concerns not well addressed by broad policy, or at times perhaps even contrary to the consensus positions of the AMA. The concerns vital to a limited segment of the profession may be of little concern or of small magnitude compared to the major problems of the profession. For example, psychiatrists face the problem of limited insurance reimbursement for their services. This is of great concern to the APA but the Delegates to the AMA do not perceive this as a priority item.

Consequently, the specialists are forming their own separate organizations in order more effectively to promote those legitimate concerns peculiar to their own specialty. Clearly this introduces a note of discord because what may be important to a specialty society may be ignored or sidetracked in the grand scale of the AMA. Frustrations are heightened, and before long one begins to see adversary positions developing.

I view this as one of the most important problems facing organized medicine. How do we accommodate the legitimate parochial concerns of the specialties into the broad context of the umbrella organizations, the AMA? There are legitimate reasons for the existence of specialty societies. Among them are quality assurance, provision of specialized postgraduate education, forums for discussion, for specialty development, and others. There is also legitimacy to the concept of a final common pathway, e.g., the AMA, for the voice and programs of organized medicine.

I support the concept of specialty societies, but hasten to add that it is the function of the AMA to represent physicians, some of whom happen to be specialists. It is important that the specialty societies provide policy input into the AMA, but even more important that once policy is developed democratically that the specialty societies abide by it. Those matters of special concerns within the specialty should be addressed by the specialty society itself. I believe this distinction can and should be made, lead-

ing to greater benefit for all.

So, therefore, there always will be the plethora of medical organizations to which each physician should belong. The county and state societies are important to provide grass roots input, the AMA is important because it is the only organization that can speak on broad issues for all physicians, and the specialty societies are important to address parochial concerns and educational issues. I hope you belong totally to organized medicine and will continue to do so. Without strong cooperative membership participation it is unlikely the profession can long survive.

Your interest in the problem is appreciated, and all good wishes to you in your new position.

(signed) James S. Todd, M.D.
(AMA Trustee)

Dr. Phoebe Hudson's Contribution

September 2, 1980

Dear Sir:

The passing of Dr. Phoebe Hudson (obituary column, August 1980 issue) deserves comment. All physicians dealing with children owe her a special debt of gratitude for leading the campaign to shatter the public's dependency on the house call.

When I joined Dr. Robert Forer in private practice almost thirty years ago there usually was such a deluge of requests for house calls that one doctor regularly spent practically his entire day one week at a time just making house calls while the other held office hours and made hospital rounds. Then we alternated assignments the following week.

Breaking with such firmly entrenched tradition did not come easily. However, when Dr. Hudson stuck her neck out and courageously wrote her article in *Medical Economics* denouncing the appropriateness and cost-effectiveness (time and money) of the practice of making house calls, it was as if overnight she crystallized the unexpressed opinion of hundreds of her colleagues and sounded the death-knell of the H.C.

(signed) Sol Browdy, M.D.

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2. Mail subscriptions	10,319	9,786
C. Total Paid Circulation (Sum of 10B1 and 10B2)	10,319	9,786
D. Free Distribution by mail carrier or other means -samples, complimentary, and other free copies	370	370
E. Total Distribution (Sum of C and D)	10,529	10,156
F. Copies Not Distributed		
1. Office use, left-over, uncounted, spoiled after printing	160	144
G. Total (Sum of E, F1 and 2—Should equal net press run shown in A)	10,689	10,300

11. I certify that the statements made by me above are correct and complete. (Signed)

Arthur White
Director of Finance and Administrative Services

12. For completion by publishers mailing at the regular rates (Section 132.121, Postal Service Manual). 39 U.S.C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates." In accordance with the provisions of this statute. I hereby request permission to mail the publication named in Item 1 at the phased postage rate presently authorized by 39 U.S.C. 3626 (Signed)

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Dec.

9 **Anesthesia for the Obese Patient**
7:30 p.m.—Helene Fuld Medical Center, Trenton
(Helene Fuld Medical Center and AMNJ)

10 **Nerve Blocks of Upper/Lower Extremities**
8-9:30 p.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

Jan.

14 **Anesthesia for Diagnostic Studies**
8-9:30 p.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

20 **Dinner Meeting**
6 p.m.—Ramada Inn, Clark
(NJ State Society of Anesthesiologists and AMNJ)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Dec.

1-2 **Advanced Cardiac Life Support Course**
6-7 9 a.m.-5 p.m.—NJ Medical School, Newark
(CMDNJ-NJ Medical School and AMNJ)

2 **Burns**
8 p.m.—Burdette-Tomlin Memorial Hospital, Cape May
(AMNJ)

3 **Topic to be Announced**
1-5 p.m.—Somerset Medical Center, Somerville
(NJ Society for Gastrointestinal Endoscopy and AMNJ)

3 **Fall 1980 Scientific Symposium: Clinical Cancer Research in NJ**
1 p.m.—The Manor, West Orange
(Oncology Society of NJ and AMNJ)

3 **Interpretation of Blood Gases**
17 **Thyroid Diagnosis and Therapy**
1-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

3 **Medical Lecture Series**
10 1-2:30 p.m.—VA Medical Center, Lyons
17 *(VA Medical Center and AMNJ)*

3 **Head and Neck Cancer**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

3 **Breast Cancer**
17 **Out-Patient Surgery**
9-11 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

3 **Cardiology Conferences**
17 3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick
(CMDNJ-Rutgers Medical School, Somerset County Heart Association and AMNJ)

3 **Monthly Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(AMNJ Endocrinology Section)

3 **Internal Medicine and Therapeutics**
10 9-11 a.m.—Roosevelt Hospital, Menlo
17 Park
(Middlesex General Hospital and AMNJ)

3 **Endocrine Conferences**
3:30-5 p.m.—Rotates between Newark Beth Israel Medical Center, College Hospital, Newark, and VA Medical Center, East Orange
(AMNJ Endocrinology Section)

3 **Medical Grand Rounds**
10 11:30 a.m.-1 p.m.—VA Medical Center,
17 East Orange
(AMNJ Endocrinology Section)

3 **Transfusion Therapy and Blood Group Serology**
10 **Platelet Function and Dysfunction**
17 **Medical Treatment of Gallstones**
24 **Nutrition Throughout the Human Life Cycle**
31 9:30-11:30 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital & AMNJ)

4 **Immunology '81**
11 4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

4 **Medical Grand Rounds**
9:30-11 a.m.—Newark Beth Israel Medical Center
(AMNJ Endocrinology Section)

5 **Renal Conferences in Nephrology**
19 2-3:15 p.m.—College Hospital, Newark
(Nephrology Society of NJ and AMNJ)

5 **Medical Grand Rounds**
11:30 a.m.-1 p.m.—College Hospital, Newark
(AMNJ Endocrinology Section)

6 **General Otorhinolaryngology**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

6 **Infection in Renal Failure**
9 a.m.-5 p.m.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center and AMNJ)

9 **Acid-Base Balance and Electrolyte Disorders**
23 **Hypertension**
30 **Doctor-Have You Been Lied To?—Film**
8-9 a.m.—Greater Paterson General Hospital, Wayne
(Greater Paterson General Hospital and AMNJ)

9 **Arrythmia Management**
8-9:30 p.m.—Shore Memorial Hospital, Somers Point
(Shore Memorial Hospital and AMNJ)

9 **What's New in Cancer Chemotherapy?**
23 **Health Care Policy: Diagnosis/Prognosis**
12 noon-2 p.m.—West Jersey Hospital, Camden
(West Jersey Hospital)

10 **Diseases of the Pituitary**
1 p.m.—Christ Hospital, Jersey City
(AMNJ)

10 **Is Atherosclerosis Reversible?**
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(Dover General Hospital, Riverside, Saint Clare's Hospital and AMNJ)

10 **Medical Lecture Series**
17 1-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

10 **Cardiology Conferences**
24 3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick
(CMDNJ Somerset County Medical Association and AMNJ)

11 **Nutrition Intervention Techniques**
5-6 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

11 **Gastric Emptying and Unexplained Dyspepsia**
8-9 p.m.—Rancocas Valley Hospital, Willingboro
(Burlington County Medical Society and AMNJ)

11 **Diseases of the Pituitary**
11:45 a.m.-1 p.m.—John F. Kennedy Medical Center, Edison
(AMNJ)

13 **The Coordinated/Uncoordinated Child**
8:30 a.m.-4:30 p.m.—NJ Medical School, Newark
(AMNJ)

13 **Cardiology Series**
14 9 a.m.-6 p.m.—Nassau Inn, Princeton
(National Foundation for Non-Invasive Diagnostics and AMNJ)

15 **Clinical Cardiology**
7-8 p.m.—Paul Kimball Hospital, Lakewood
(Paul Kimball Hospital and AMNJ)

Academy of Medicine of New Jersey
NJSDH—Genetics Services Program
CMDNJ—Rutgers Medical School
Hemophilia Association of New Jersey

Presents A Symposium On

HEMOSTATIC DISORDERS—PATHOPHYSIOLOGY AND MANAGEMENT

on
Saturday, November 8, 1980
at
CMDNJ—Rutgers Medical School
Piscataway, N.J.

The program will include presentations by nationally prominent speakers on the clotting mechanism, pathophysiology of hemostasis, Von Willenbrand's Disease, disorders of platelet function, anticoagulant therapy, thrombolytic therapy and current management of Hemophilia. The program is designed for internists, pediatricians, general practitioners and dentists as well as allied professionals working in the field.

For Further Information Contact:

Henrietta Golub
Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, N.J. 08648
Phone: (609) - 896-1717

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16 **Gastrointestinal Bleeding**
2 p.m.—St. Mary's Hospital, Orange
(AMNJ)

16 **Venereal Diseases: Diagnosis/Treatment**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

17 **Fibrotic Lung Diseases**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

17 **Alcohol Hepatitis and Its Complications**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

19 **Diabetes**
12 noon—Freehold Area Hospital
(AMNJ)

23 **Diabetes**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

23 **Adrenal Diseases**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

Jan.

1 **Medical Grand Rounds**
9:30-11 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section of AMNJ)

2 **Renal Conferences in Nephrology**
16 2-3:15 p.m.—College Hospital, Newark
(Nephrology Society of NJ and AMNJ)

2 **Medical Grand Rounds**
11:30 a.m.-1 p.m.—College Hospital, Newark
(Endocrinology Section of AMNJ)

5-6 **Advanced Cardiac Life Support Course**
28- 9-5 p.m.—NJ Medical School, Newark
29 *(CMDNJ and AMNJ)*

6 **Thyroid Diseases**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

7 **Diabetes Mellitus**
1-2:30 p.m.—VA Medical, Lyons
(VA Medical Center and AMNJ)

7 **Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(Endocrinology Section of AMNJ)

7 **Coronary Artery Disease Workshop**
9-11 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

7 **Endocrine Conferences**
14 3:30-5 p.m.—Rotates between, Newark
21 Beth Israel Medical Center, College
28 Hospital, Newark, and VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

7 **Medical Grand Rounds**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(AMNJ)

7 **Medical Lecture Series**
14 1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

7 **Internal Medicine and Therapeutics**
14 9-11 a.m.—Roosevelt Hospital, Menlo
21 Park
28 *(Middlesex General Hospital and AMNJ)*

8 **Recurrent Ventricular Tachycardia**
8-9 p.m.—Burlington County Memorial Hospital, Mount Holly
(Burlington County Medical Society and AMNJ)

8 **Immunology '81**
15 4-6 p.m.—Copewood Street, Camden
22 *(Institute for Medical Research and*
29 *AMNJ)*

13 **Helping Your Patient with Cosmetics**
8-10 p.m.—Schering Corporation, Kenilworth
(NJ Dermatological Society and AMNJ)

13 **Athletic Injuries**
27 **Use and Misuse of Oxygen Therapy**
12 noon-2 p.m.—West Jersey Hospital, Camden
(West Jersey Hospital)

14 **Adrenal Diseases**
11:30 a.m.—Rahway Hospital
(AMNJ)

14 **Hypertrophic Sub-Aortic Stenosis**
2 p.m.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)

14 **Lesions of the Oral Cavity**
21 **Respiratory Failure**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

14 **Cardiology Conferences**
28 3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick
(CMDNJ, Somerset County Medical Association and AMNJ)

14 **Medical Lecture Series**
21 1-3 p.m.—Christ Hospital, Jersey City
28 *(Christ Hospital and AMNJ)*

15 **Newer Drugs in Hypertension and Mechanisms of Diuretic Actions**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

15 **Postgraduate Allergy Workshops**
18 Winter Conference-Pocono Manor Inn Pocono Manor, PA
(Holy Name Hospital and AMNJ)

16 **Hepatitis**
12 noon-Freehold Area Hospital
(AMNJ)

19 **Coagulation Defects**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

20 **Common Geriatric Diseases**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

20 **Idiopathic Thrombocytopenic Purpura**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

21 **Adult Respiratory Distress Syndrome**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

21 **Dermatological Conference**
6 p.m.—Rutgers Community Health Plan Bldg., 51 U.S. Highway 1 & Rt. 18, New Brunswick
(Rutgers Medical School)

27 **Topic to be Announced**
7:30-9 p.m.—Coachman Inn, Cranford
(New Jersey Blood Club and AMNJ)

NEUROLOGY/PSYCHIATRY

Dec.

1 **Stuttering Following Incest**
8-10 p.m.—192 Chittenden Rd., Clifton
(Essex Psychiatric Doctors Seminars and AMNJ)

1 **Case Presentation**
8 **Multiple Sclerosis**
15 **Case Presentation**
22 **"AVM"**
11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

2 **Psychiatric Case Conferences**
9 7:30-9:30 a.m.—Trenton Psychiatric
16 Hospital
23 *(Trenton Psychiatric Hospital and*
30 *AMNJ)*

3 **Ongoing Child Psychiatry Case**
10 **Conference and Lecture**
17 8:30-10:30 a.m.—Trenton Psychiatric
24 Hospital
31 *(Trenton Psychiatric Hospital and AMNJ)*

3 **Case Presentation**
10 **Occlusive Cerebrovascular Disease**
17 **Case Presentation**
24 11:30-12:30 p.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

3 **Epidemiology of Epilepsy**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

3 **Psychosocial Stresses in Human Life Cycle**
10 **Short-term Psychodynamic Psychotherapy**
17 **Organic Brain Syndrome**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

4 **Diagnosis and Treatment of Chronic Pain**
11 **Hypnosis Update**
18 **Sex and Communication between Couples**
12 noon-1:30 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

4 **Sleep Disorders in DSM III and Other**
11 **Current Sleep Developments**
18 11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

9 **Psychotropic Medication**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

10 **Movement Disorders: Update**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

10 **Endorphins, Enkephalins, and Schizophrenia**
8:30-10:30 p.m.—Guido's Restaurant, Hackensack
(North Jersey Psychiatric Society and AMNJ)

15 **Headache**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

17 **Mental Patients in the Street**
8-10 p.m.—MayFair Farms, West Orange
(Tri-County Chapter of the NJ Psychiatric Association and AMNJ)

17 **Autogenic Training in Medicine and Psychotherapy**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation)

Jan.

3 **Cancer Related Depression**
16 **The Private Practice of Family Therapy**
17 **Cerebral Metabolism**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation)

5 **Psychiatric Complications in a Juvenile Diabetic**
8-10 p.m.—4 Garden Place, Nutley
(Essex Psychiatric Doctors Seminars and AMNJ)

5 **Evaluation of Diseases of the Autonomic**
12 **Nervous System**
19 11:30 a.m.-12:30 p.m.—Bergen Pines
26 County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

6 **Psychiatric Case Conference**
13 7:30-9:30 a.m.—Trenton Psychiatric
20 Hospital
27 *(Trenton Psychiatric Hospital and AMNJ)*

7 **Ongoing Child Psychiatry Case**
14 **Conference and Lecture**
21 8:30-10:30 a.m.—Trenton Psychiatric
28 Hospital
(Trenton Psychiatric Hospital and AMNJ)

8 **Case Presentation**
22 **Emergency Use of Psychotropic Drugs**
29 **Psychopharmacology**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

8 **Sleep Disorders**
24 **Case Reviews**
31 **Family Therapy-Case Presentation**
12 noon-1:30 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation)

10 **Psychotherapy of Schizophrenia**
12 noon-2 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation)

14 **Psychohistory**
21 **Family Therapy**
28 **Behavioral Therapy of Borderlines**
1-3 p.m.—Ancora Psychiatric Hospital
(Ancora Psychiatric Hospital and AMNJ)

21 **Affective Illnesses**
1:30-3 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)

21 **Psychiatric Disorders in Drug Abusers**
1:30 p.m.—Trenton Psychiatric Hospital
(AMNJ)

22 **A Psychoanalytic Note on Richard Strauss**
8:30-11 p.m.—Hackensack Hospital
(NJ Psychoanalytic Society and AMNJ)

OBSTETRICS/GYNECOLOGY

Dec.

3 **Distinguished Lectures in Obstetrics/Gynecology**
6-7 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)

Jan.

7 **Distinguished Lectures in Obstetrics/Gynecology**
6-7 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)

22 **Bladder and Bowel Repair During Gynecologic Surgery**
4-5:30 p.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

PATHOLOGY

Dec.

13 **Workshop**
9 a.m.-4 p.m.—Medical Society of NJ Executive Offices, Lawrenceville
(NJ Society of Pathologists and AMNJ)

PEDIATRICS

Dec.

4 **Thyroid Disorders in Children**
9 a.m.—Freehold Area Hospital
(AMNJ)

15 **Pediatric Pulmonary Disease**
12 noon-1 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital and AMNJ)

19 **Pediatric Pharmacology/Therapeutics**
7:45-9:15 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

Jan.

16 **Endocrinology**
7:45-9:15 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

19 **Neonatal Seizures**
12-1 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital and AMNJ)

RADIOLOGY

Jan.

14 **Case Presentations**
7:45-10:15 p.m.—Morristown Memorial Hospital
(Radiological Society of NJ and AMNJ)

14 **Radiology-Nuclear Medicine**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(AMNJ)

15 **Pediatric Radiology**
8 p.m.—Hospital Center at Orange
(Radiological Society of NJ and AMNJ)

15 **The Esophagus in the Newborn and Infant**
8 p.m.—Hospital Center at Orange
(Radiological Society of NJ and AMNJ)

21 **Dinner Meeting**
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

22 **Visiting Professorship Program**
1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston
(St. Barnabas Medical Center and AMNJ)

GENERAL SURGERY

Dec.

2 **Tumor Conferences**
9 12 noon-1 p.m.—Morristown Memorial
16 Hospital
23 *(Morristown Memorial Hospital and*
30 *AMNJ)*

2 **Emergency Management of Trauma of Medical Systems**
8-9 a.m.—Greater Paterson General Hospital, Wayne
(Paterson General Hospital and AMNJ)

13 **Annual Meeting**
Resorts International Hotel, Atlantic City
(New Jersey Chapter, American College of Surgeons)

13 **Tumor Conferences**
12 noon-1 p.m.—West Hudson Hospital Kearny
(West Hudson Hospital and AMNJ)

16 **Surgical Lecture Series**
8-10 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

18 **Septic Shock**
7:30-9 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

Jan.

2 **Tumor Conference**
16 12 noon-1 p.m.—Elizabeth General Hospital
(Elizabeth General Hospital and AMNJ)

6 **Tumor Conferences**
13 12 noon-1 p.m.—Morristown Memorial
20 Hospital
27 *(Morristown Memorial Hospital and AMNJ)*

7 **Orthopedic Problems**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(AMNJ)

14 **Tumors of the Biliary Tract**
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(Joint Education Committee of Dover General, Riverside & St. Clare's Hospitals, Denville and AMNJ)

15 **Carotid Artery Surgery**
7:30-9 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

24 **Thrombo-Embolic Complications Following Surgery**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

SURGICAL SPECIALTIES (includes ENT, Nurosurgery, Ophthalmology, Orthopedic, Plastic, and Vascular Surgery)

Dec.

13 **General Ophthalmology**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

16 **Arthroscopy of the Knee**
8-10 p.m.—Englewood Club
(Englewood Surgical Society and AMNJ)

18 **Spinal Cord Injury Service Quarterly Meetings**
1-2:30 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

3 **Case Presentation**
10 **Occlusive Cerebrovascular Disease**
17 **Case Presentation**
24 11:30-12:30 p.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

5 **Tumor Conference**
19 12 noon-1 p.m.—Elizabeth General Hospital
(Elizabeth General Hospital and AMNJ)

215th Annual Meeting
Medical Society of New Jersey
May 15-19, 1981

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OBITUARIES

Dr. R. A. P. Cupaiuoli

A senior member of the Essex County component, Richard A. P. Cupaiuoli, M.D., died on September 5. A native of New Jersey, born in 1907, Dr. Cupaiouli received his medical degree from the University of Virginia, class of 1935. He established a practice in general medicine, later specializing in internal medicine and rheumatology, in Maplewood, where he remained until retirement to Lakehurst in 1977. Dr. Cupaiuoli had been on the staff at the Hospital Center in Orange and at St. Barnabas Medical Center in Livingston. He was a member of the American Academy of Family Physicians and during World War II served in the medical corps of the United States Navy from 1940 to 1946.

Dr. William M. Epstein

William M. Epstein, M.D., a member of our Essex County component, died on August 26. Dr. Epstein, a native of New Jersey, earned his medical degree at Temple University, class of 1934. Prior to retirement in 1975, when he moved to Elizabeth, he practiced general medicine in Roselle Park. He had been affiliated with Presbyterian Hospital in Newark, and Elizabeth General and St. Elizabeth's Hospitals in Elizabeth. Dr. Epstein was a member of the American Academy of Family Practice. During World War II he served in the medical department of the AUS. Dr. Epstein was 73 years of age at the time of his death.

Dr. Harold F. Hughes

We just have learned of the death on July 12, in Burdette Tomlin Memorial Hospital, of Harold Franklin Hughes, M.D., a member of our Cape May County component. Born in West Cape May in 1912, Dr. Hughes was graduated from Hahnemann Medical College in 1938, and pursued a career in general medicine in Cape May. Dr. Hughes was affiliated with Burdette Tomlin Memorial Hospital, serving as chief of the medical staff. During World War II he served in the medical department of the AUS.

Dr. Robert E. Koenig

Robert E. Koenig, M.D., a member of our Middlesex County component, died on August 26 after a long illness. A native of Vienna (Austria), Dr. Koenig was graduated from the University of Vienna College of Medicine in 1936 and emigrated to the United States in the early 1940s. He was a family practitioner in Jamesburg until retirement in 1975 because of illness. He had been affiliated with St. Peter's and Middlesex General Hospitals in New Brunswick. Dr. Koenig was 70 years old at the time of his death.

Dr. Thomas H. McGlade

One of Camden County's well-known practitioners, Thomas H. McGlade, M.D., of Haddonfield, died on August 30 at Ocean County Hospital in Manahawkin after a long illness. Born in 1906, Dr. McGlade was graduated from Jefferson Medical College, class of 1932, and pursued a career in otolaryngology, becoming board certified in that specialty. He was a Fellow of the American College of Surgeons and of the American College of Ophthalmology and Otolaryngology. Dr. McGlade had been affiliated with the Cooper Medical Center and Our Lady of Lourdes Hospital in Camden, Zurbrugg Memorial Hospital in Riverside, Burlington County Hospital in Mount Holly and the Camden County General Hospital at Lakeland. He was active in medical society affairs and had been president of the Camden County Medical Society and a member of MSNJ's Committee on Medicine and Religion and the MSNJ Auxiliary Advisory Committee. His widow, Dorothy McGlade, was president of the Medical Society of New Jersey Auxiliary in 1951-1952.

Dr. E. J. Ortega-Arza

Enrique J. Ortega-Arza, M.D., a member of our Essex County component, died on July 29 in Palisades General Hospital in North Bergen. A native of Cuba, Dr. Ortega-Arza received his medical education at the University of Havana School of Medicine, graduating in 1937. He emigrated to the United States in 1966 and served an internship at Montgomery Hospital in Norristown, Pennsylvania, and did graduate work at the Essex County Sanatorium in Verona and the Essex County Hospital Center at Cedar Grove. Before retirement in 1976, he had been affiliated with the facility at Cedar Grove, practicing general medicine with a special interest in geriatrics. Dr. Ortega-Arza was 72 years old at the time of his death.

Dr. Joseph D. Napoli

A well-known orthopedic surgeon, Joseph D. Napoli, M.D., died in Palisades General Hospital in North Bergen on August 24. Dr. Napoli practiced his specialty in Union City for 38 years until retirement three years ago. A native of New York City, Dr. Napoli was graduated from Georgetown University Medical School in 1933 and pursued graduate training in orthopedics at Hartford Municipal Hospital in Connecticut. He was on the staffs of Jersey City Medical Center and Palisades General Hospital. Dr. Napoli had been physician and surgeon for the State Athletic Commission of New Jersey. He was a Fellow of the American Geriatric Society and a member of the American Association of Railway Surgeons. Dr. Napoli was 75 years of age at the time of his death.

Dr. John N. Pannullo

Word just has been received of the death on August 19 of John N. Pannullo, M.D., a member of our Essex

County component. A native of Italy, born in 1896, Dr. Pannullo was graduated from Long Island College of Medicine in 1918 and pursued a career in the practice of obstetrics and gynecology. He was a Fellow of the American College of Obstetricians and Gynecologists and of the International College of Surgeons. Dr. Pannullo had been on the staff at Presbyterian and St. James Hospitals in Newark and the Clara Maass Memorial Hospital in Belleville. In 1968, he was recipient of MSNJ's Golden Merit Award, indicating 50 years of medical practice. He retired in 1978.

Dr. Spencer T. Snedecor

Spencer Treadwell Snedecor, M.D., the 144th president of MSNJ and the youngest to hold that office—1936-1937—died on August 23 in Memphis, Tennessee where he had been living in retirement since 1975. Born at the turn of the century, Dr. Snedecor was graduated from Columbia University's College of Physicians and Surgeons in 1923 and pursued a residency in orthopedic surgery. He was a Fellow of the American College of Surgeons and had been affiliated with the Hackensack Hospital all of his professional life. He was founder of the department of orthopedics there and the prime mover in the development of the physical therapy department and the burn unit. He also was a member of the board of governors of the hospital. In addition he had been on the staff at the Valley Hospital in Ridgewood and Bergen Pines Hospital in Paramus. Beginning in the early 1950s, Dr. Snedecor elected to spend his vacations as a consultant, lecturer and surgeon to mission hospitals of all denominations throughout the world—Central and South America, Africa, the Middle East and Asia. He was chairman of the Christian Medical Council of the National Council of Churches and a president of the World Overseas Ministries of the Reformed Church of America. He was chairman of the emergency department committee of the New Jersey Chapter of the American College of Surgeons and locally was active in his county medical society (Bergen) serving eight years as secretary. During World War II, Dr. Snedecor was on active duty in the medical department of the AUS—in the Pacific, and at the Walter Reed Hospital in Washington and the Valley Forge Military Hospital in Pennsylvania. Dr. Snedecor was an avid yachtsman and served as ship surgeon on the schooner "Mistress" in the Transatlantic Yacht Race of 1931. In 1973 he was recipient of MSNJ's Golden Merit Award indicating 50 years of medical practice.

BOOK REVIEWS

Harrison Stanford Martland, M.D.: The Story of A Physician, A Hospital, An Era.

Samuel Berg, M.D. New York, Vantage Press, 1978. Pp. 223. Illus. ($8.95)

"Martland—who?" say the young and foreign physicians. "Yes, I've heard of him," say some of his survivors. "You mean Martland Hospital," say others.

It is high time that both the "good" and the "evil" be disinterred through the small medium of this book review on a kaleidoscopic, constructive giant of an era of medicine commensurate with the age of Pericles for breadth, glory and accomplishment. Martland's life spanned part of the period of ascendency of this era, which one hopes is still growing, and Dr. Samuel Berg has delineated with accurate details the points at which Martland's life impinged on the ascending curve.

Neither the "good" nor the "evil" have been neglected in details familiar to many of Martland's contemporaries. Every aspect of personal history and habits of the man, the doctor and the pathologist are faithfully depicted. The heights are reached in the story of the radium watch-dial painters' disease leading to bone sarcoma and the description of the honors bestowed on this industrious doctor. Dr. Martland was one of the few non-New Yorkers to head the New York Academy of Medicine. Dr. Martland foresaw the implications of radio-active hazards and did his best to warn against them. By contrast his human frailities are shown in some of his picayune actions toward some of his own appointees as assistant pathologist. In the Appendices C and D, respectively, are listed an almost complete bibliography of his publications and a very nostalgic list of all the known interns of the erstwhile famous Newark City Hospital from 1883 thru 1941. (May its successor gain an equal fame.) Wells P. Eagleton, cranial surgeon, Harrison S. Martland, the author, Dr. Berg and your reviewer are included with the great, the nearly great and the nearly forgotten.

This book should be a delight to the enjoyers of vignettes of medical history as well as the appreciators of well-researched and constructed biographies.

Everett O. Bauman, M.D.

Development of Mental Health in Infancy.

Science Monograph. National Institute of Mental Health. Washington, DC. U.S. Department of Health and Human Services, 1980. Pp. 106. (No price given.)

This monograph is the latest of a long list of research reports emanating from the National Institute of Mental Health. These monographs which cover a wide range of topics provide the reader with a survey of the latest research findings, and are directed primarily to individuals engaged in active clinical investigation. Their usefulness for the practicing physician, in large part, depends upon the author's ability to organize an enormous amount of information so that a recognizable theme develops in the presentation.

The subject matter of the present report is particularly broad, covering the psychological, biological, and sociological aspects of mental health in infancy. Unfortunately, the author fails to develop recognizable themes and, for this reason, the subject matter lacks cohesiveness. Additionally, the research findings reported upon are at times contradictory and most often, the author fails to support one point of view over another.

Despite the obvious organizational weaknesses of the monograph, it is clear that the author has reviewed the literature exhaustively, and there is hardly an area of infant development which is not touched upon.

Some of the topics include the neonate's repertory of behaviors, neonate assessment, the effect of environment on the infant's mental health, genetic and prenatal influences, the effect of early deprivation, mother-infant interaction, and social-economic influences on infant development. There is also a short final section on clinical interventions.

If the reader is interested in the latest research in the field of infant development, this monograph provides a good starting point. In particular, the bibliography will be helpful. If, on the other hand, the reader is interested in practical clinical issues, I suggest that he look elsewhere.

Finally, comprehension of the material will be easier if one first reads the final summary. It provides a much-needed overview that could have served well as a preface.

Irwin W. Pollack, M.D.

Sports Medicine for the Athletic Female.

Christine E. Haycock, M.D., ed. Oradell, New Jersey, Medical Economics Company Book Division, 1980. Pp. 420. ($27.50)

Although we know that women have beaten men in athletics since the days of Atalanta, it is only in fairly recent times that the fair sex (dare I use that adjective?) has taken a prominent position in the world of sports. The present book appeared as a logical recognition of this development, and contains much useful information for those whose duty it is to supervise the physical development of adolescent girls. It long has been known that girls mature more rapidly than boys, at least until the age of puberty; it is now thought that the obvious differences in the adult stage occur only as the result of the more sedentary occupations and habits of women. This book puts to rest many of the old shibboleths warning women against exercising during the menstrual period and the dangers of excessive muscular development.

Seldom have I reviewed a book that seems so carefully planned. Dr. Haycock has called to her aid no less than thirty specialists—most of them associated with the New Jersey Medical School—to cover the essentials of anatomy, physiology, as well as trauma and its emergency care. No system of the body remains unconsidered, although the space allotted to some, such as the skin, seem precariously thin. Nevertheless, as a pioneer work in a rapidly developing field this book has much to recommend it.

Morris H. Saffron, M.D.

Basic Histology, 3rd ed.

L. C. Junqueira and J. Carneiro. Los Altos, CA, Lange, 1980. Pp. 504. Illustrated. ($15.50)

This firmly and attractively bound, soft-cover book is comprised of 24 chapters, two color plates and a five-page, three-columned, very complete index. There are many black and white illustrations, photographs of excellent quality, drawings, and beautifully focused electron micrographs.

The various chapters include methodology using the light microscope, histo- and cytochemistry, phase contrast microscopy, electron microscopy and methods of studying cells and tissues *in vivo*. All of that is in the first chapter. The following 23 chapters include excellent descriptions of every organ and tissue in the human body.

As a practicing pathologist of many years I find this truly a delightful book and a pleasure to review. For me it serves as a beautifully illustrated standard for just what is "normal" (not always easy). I will keep it on my desk on the shelf with the group of books I classify as "always ready when needed."

In the preface it is recommended chiefly for medical students. I would strongly suggest it also for diagnostic tissue pathologists who teach residents and medical students.

This is a very good book, reasonably priced and I highly recommend it to all who have need to use knowledge of cell and tissue structure.

Hugh F. Luddecke, M.D.

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D. Morse, M.D., et al.

Computerized Tomography of the Thorax
A. D. Carilli, M.D., et al.

Adolescent Breast Disease
M. S. Skiles, M.D., et al.

Food Allergy
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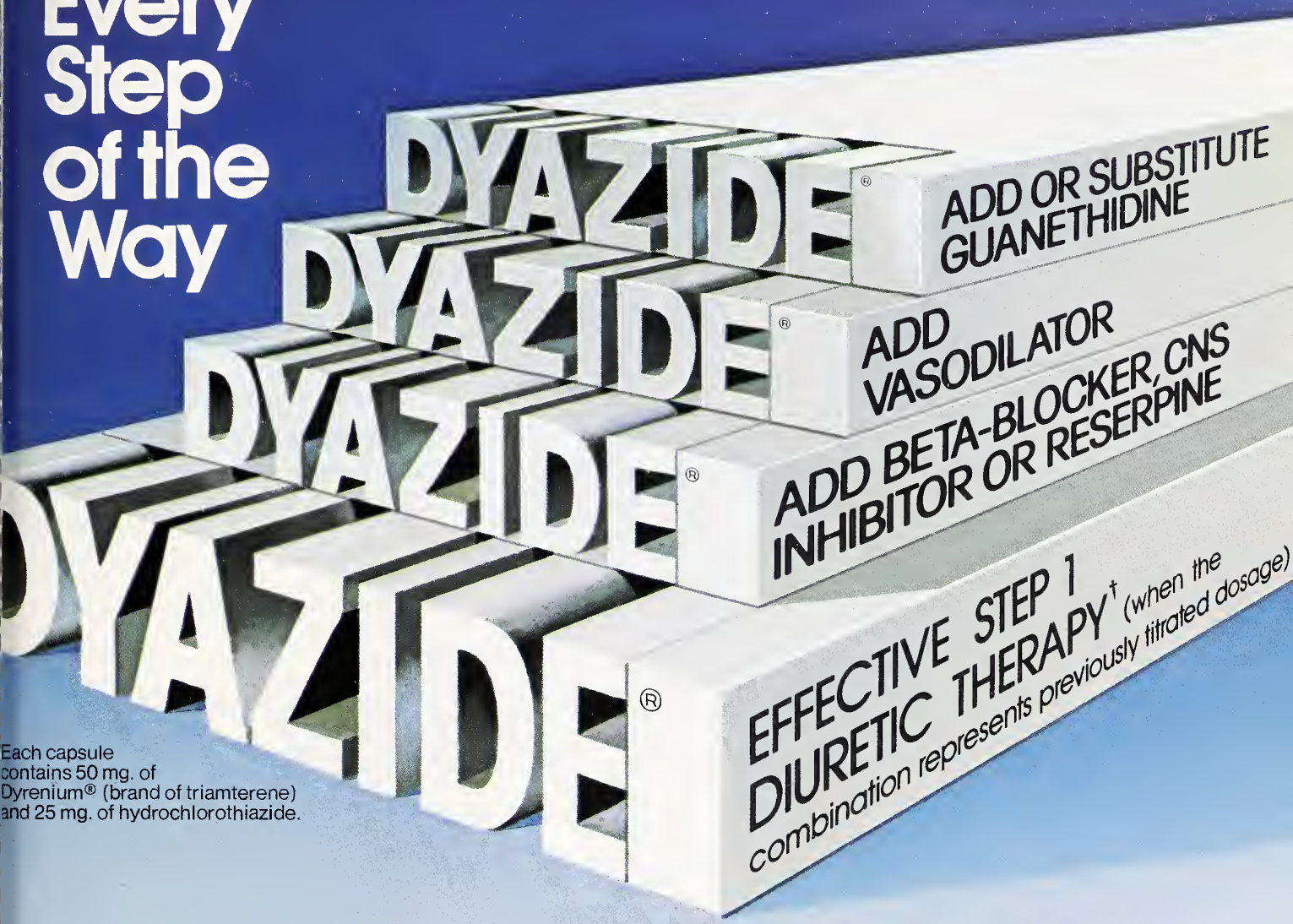

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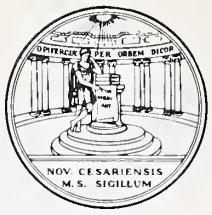

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America's First Medical Society

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Again we thank John L. Krause, Jr., M.D., of Cherry Hill for our cover. The photograph was taken in the Pine Barrens of New Jersey during the winter of 1978.

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Thirty-Month Report—Medical Inter-Insurance Exchange of New Jersey

The following report is a survey of the professional liability experience of the Medical Inter-Insurance Exchange of New Jersey. It covers a 30-month period from February 1, 1977 to July 31, 1980, and is authored by Peter Sweetland, President of the New Jersey State Medical Underwriters, and Bernard Genest, Director of Claims Administration.

The Medical Inter-Insurance Exchange of New Jersey (MIIENJ) keeps its statistics by cases and by files. A case represents an occurrence. A file represents a defendant. Consequently, it is possible to have one case with several files. The statistics discussed in this report represent files on claims and suits for the initial 30-month period of operation of MIIENJ.

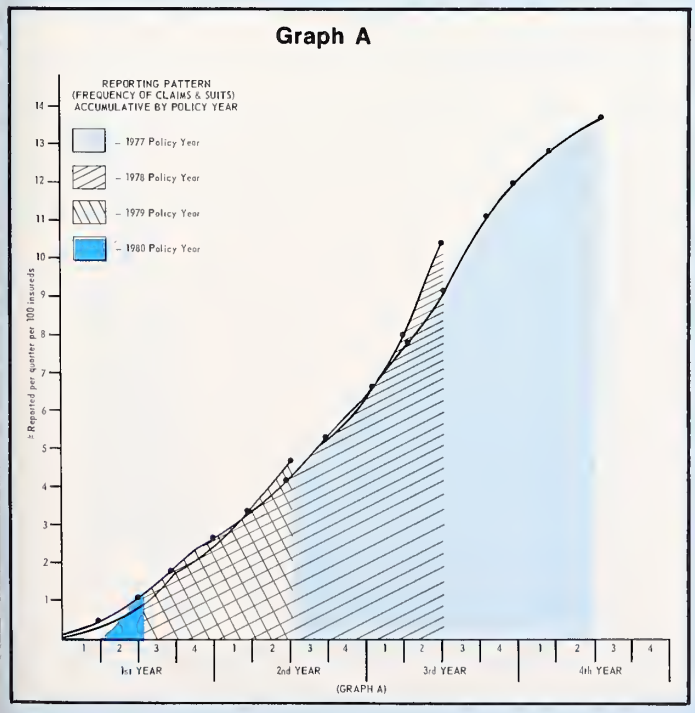
FREQUENCY AND SEVERITY

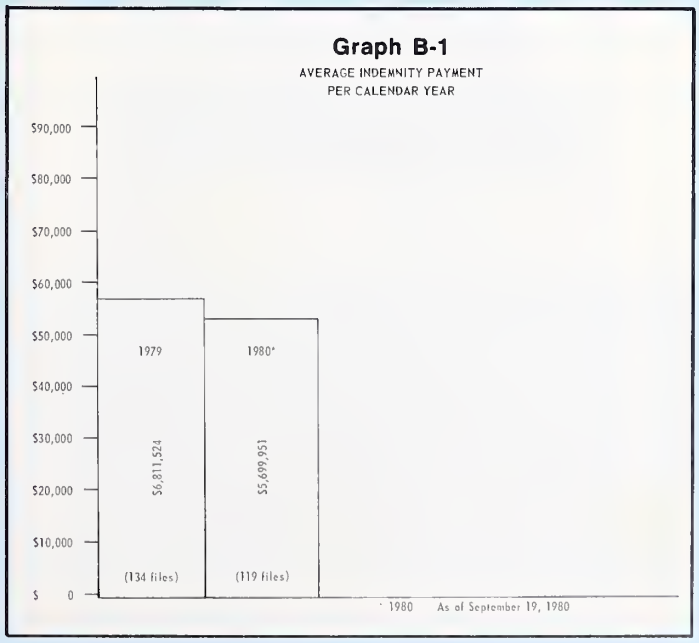
The claims experience of any insured population is measured by (1) *frequency* of claims and by (2) *severity* of claims. *Frequency* illustrates the gross number of claims being made in relation to the number of insureds. Graph A below depicts the *frequency* of claims reported by policy year and its growth in each quarter following inception. Except for the latest quarter of 1978 and 1979, the rate of *frequency* by quarter has remained unchanged when each policy year is compared to its predecessor. Nationally, the increase in *frequency* had stabilized in the mid-seventies but has since taken an upward turn. MIIENJ's pattern does not seem to follow the national results.

A critical question now is what happens to these results over the next nine to twelve months. If the Exchange's structure indeed has encouraged accelerated reporting, the rate of increase in *frequency* for mature years should level off. The most recent actuarial projects of 1977 results speculated that the ultimate *frequency* of claims and suits per 100 insured would be about 20. By next year at this time, we will have a much more definite indication of whether or not the actual result is much lower. Of concern is the fact that the most recent quarter figures for 1978 and 1979 show a higher rate than that reported for 1977. Over the next three or four quarters, we will know for sure whether this was a temporary distortion or the first indication that *frequency* rates once again are increasing in year-to-year comparisons.

It should be noted that the severe upward curve of the graph does not indicate any problem. Because these statistics are accumulative, they represent the expected pattern of reporting for each policy year. The important point to examine is the relationship of the curve for one policy year with that of another policy year. For example, the experience at the end of the second year of policy year 1977 is 6.4 claims per 100 insureds while that of the second year of policy year 1978 is 6.2 claims per 100 insureds.

Graph B-1 illustrates *severity:* the present average amount of indemnity paid on closed files during 1979 and during

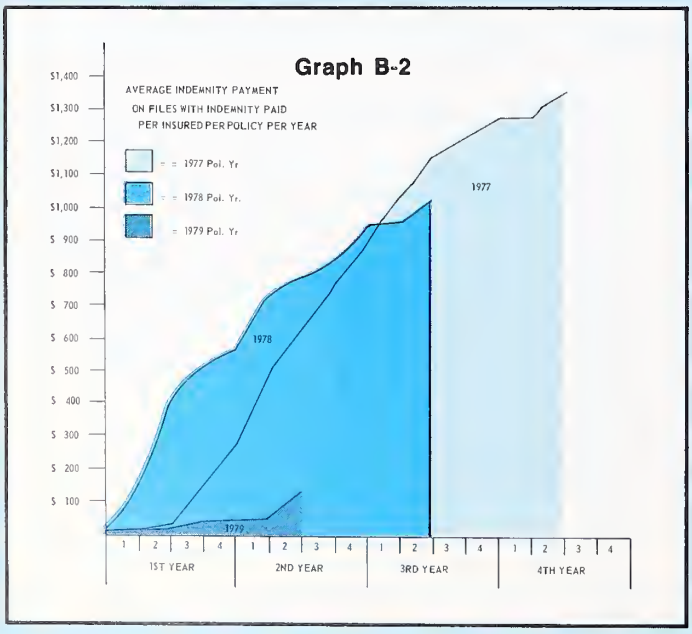




1980. There is an actual decrease in the severity of loss which may be attributed to the rapid disposition of meritorious cases. It is an insurance industry assumption that the longer it takes to dispose of a case, the more expensive it is both for indemnity and expense. The latest National Association of Insurance Commissioners (NAIC) Report indicated a 30 percent *increase* in *severity* during the last two years of the study (1977-1978) as well as a 30 percent increase from 1976 to 1977. The paid cases in the NAIC study took an average of 29 months to dispose of from the date reported whereas it has taken the Medical Inter-Insurance Exchange of New Jersey an average of nine months to dispose of paid cases thus far.

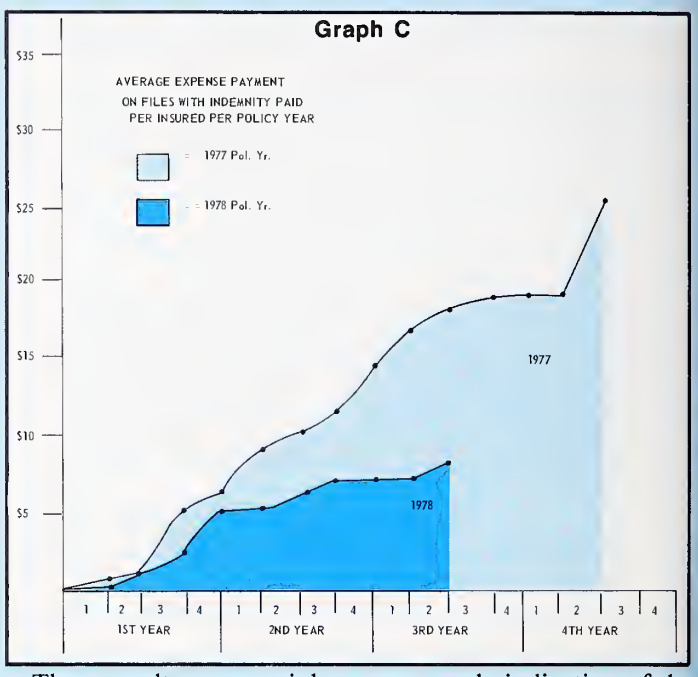
Graph B-2 illustrates *severity* by allocating indemnity paid over the entire insured population of MIIENJ by policy year and then by year in which payment was made. By looking at the 1978 policy year experience, one can see that more large losses were paid earlier than for the 1977 policy year in the first eight quarters; but, that moving into the third year of policy year 1978, the average payments are below those of 1977. This is merely a reflection of the findings in Graph B-1.

While an analysis of these average indemnity figures yields some optimism regarding final expected averages, these results are quite different from normal industry numbers. Traditionally, early figures have been very low and averages, such as the Exchange now reports, have not been seen for many years. Unfortunately, the very approach to prompt disposition of deserving cases, which we believe will produce ultimate savings, produces a temporary distortion in the numbers used to make rates. Until we have a few more years of data, the actuaries will have to make adjustments to the expected results projected by the Exchange's current figures. Just how extensive the adjustment must be is very difficult to quantify and it may be prudent to continue to be conservative for the time being.



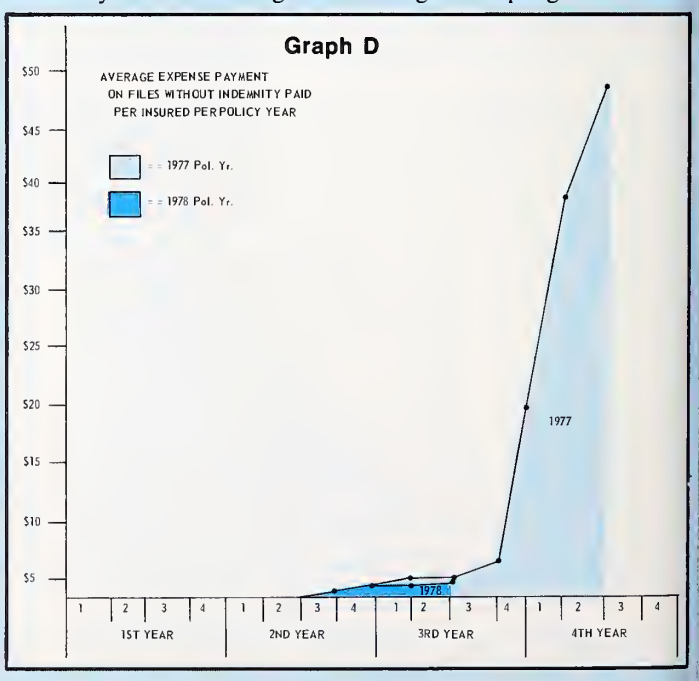
LOSS CONTROL PROGRAM

A component of *severity* is the expense associated with the disposition of a claim, i.e., legal expenses, duplication of records, expert witness fees, etc. These are referred to as allocated loss adjustmemt expenses (ALAE). MIIENJ's Loss Control Program has attempted to control this factor by the judicious use of its claims staff and defense counsel in conjunction with the Peer Review System. By extracting meritorious cases before they reach the legal system, substantial savings on the ALAE can be effected. Nationally, the ALAE on closed claims against physicians can consume 18+ cents of each dollar of indemnity paid. The experience of the MIIENJ is significantly different. On paid claims, the MIIENJ has spent one cent of ALAE for each dollar of indemnity paid. Graph C depicts the average expense per insured where indemnity was paid. (The experience for the years 1979 and 1980 was too small to be graphed.)



These results are certainly a strong early indication of the positive effect of the Exchange's present method of claims management. While average claim values will not show relative improvement for a while, actual allocated loss adjustment expense is already lower than expected and will be examined in near term rate calculations.

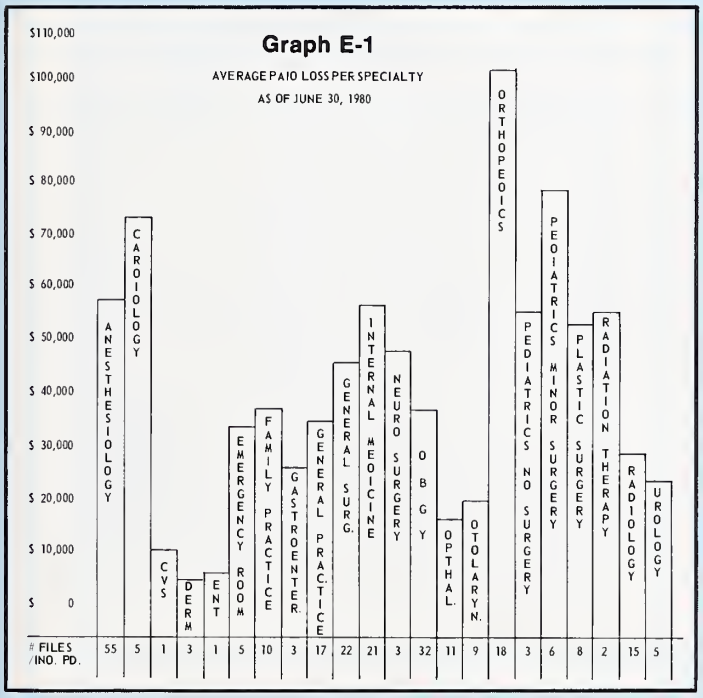
Graph D clearly demonstrates the fact that the costs of pursuing those cases which are found to be defensible is going to be higher. As you know, the Exchange intends to defend all non-meritorious cases and it is this group which will incur the higher average expense. It is far too early to reach a specific judgment on the final averages, but Claims Administration believes that the ultimate figures will be lower than expected in this category as well. This is the result of a very deliberate litigation management program.

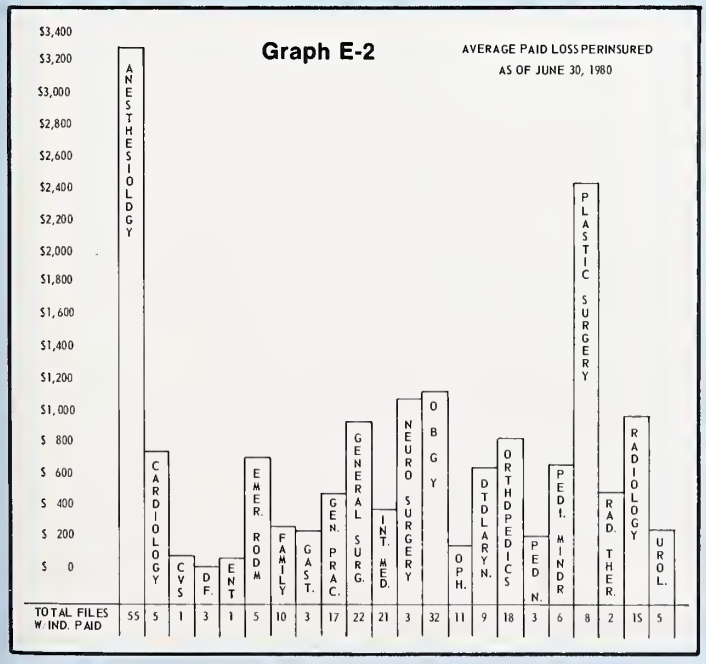


FREQUENCY AND SEVERITY AS IT APPLIES TO MEDICAL SPECIALTIES

Graph E-1 calculates the total dollars of indemnity paid in each specialty divided by the number of *files* on which payment was made. Graph E-2 calculates the total dollars of indemnity paid in each speciality divided by the number of insured *physicians* in that specialty. It is most important that both of these graphs be considered in conjunction with one another. For example, graph E-1 shows orthopedic surgeons to have an average paid loss of $100,103 and anesthesiologists to have an average paid loss of $59,983.

It appears from studying graph E-1 that orthopedic physicians have had far worse experience than that of the anethesiologists. This would not be a valid assumption. There were 18 paid files arising from an insured based of 249 orthopedic surgeons as opposed to 55 paid files arising from an insured base of 268 anesthesiologists. Graph E-2 takes this into account by allocating the same amount of indemnity dollars paid for each specialty among all the insured population in that specialty. Therefore, in reality, anesthesiologists, as a group, have experienced a higher average paid loss per insured.

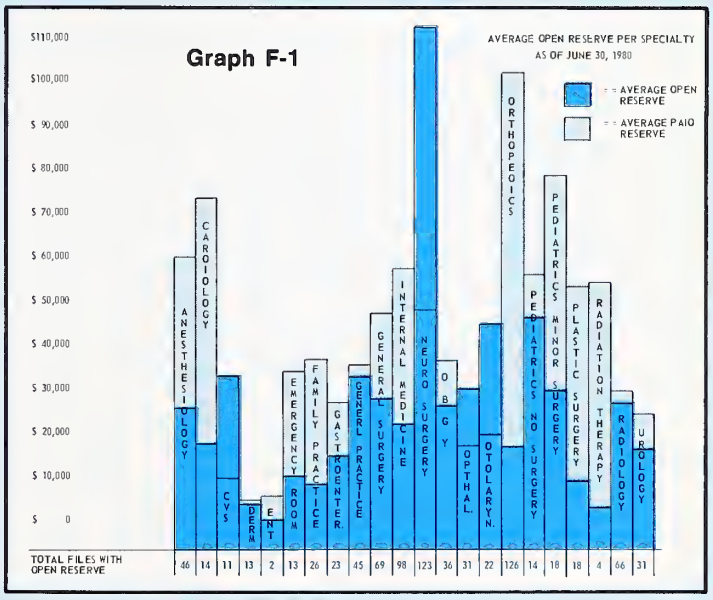


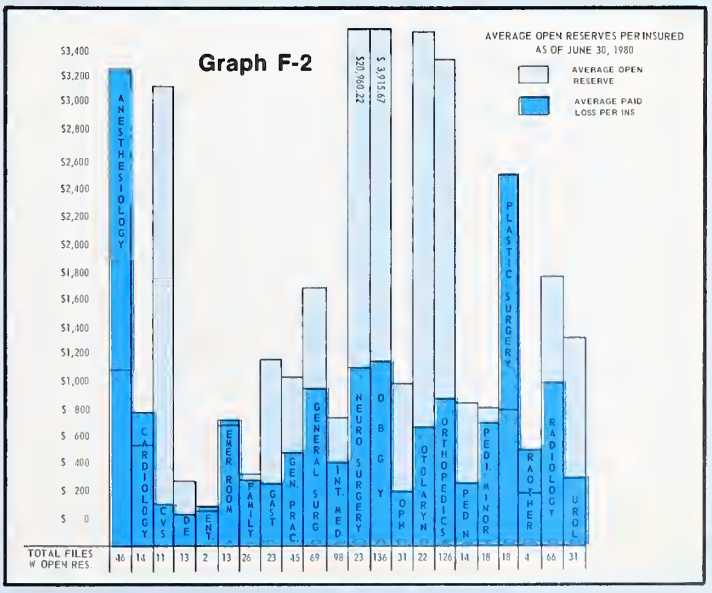


OPEN FILE RESERVES

To this point we have discussed 617 closed files which are *faits accomplis.* As of July 31, 1980, there were also 1079 open files. Every claim or suit that is reported to MIIENJ is a liability to the company. The amount of this liability is based on the estimated dollars of exposure. These are referred to as case reserves. MIIENJ has set aside $35,995,050 in case reserves as of July 31 for future exposure on these reported and still open files.

Graph F-1 superimposes on graph E-1 the average dollars reserved per open *loss* by specialty. Looking at orthopedics once again, one can see that the open orthopedic files represent a lower average value than the closed orthopedic files. Graph E-1 simply indicates that MIIENJ *paid* an average of $100,103 per file while graph F-1 indicates reserves of $16,559 per open file for future liability exposure. If these case reserves are adequate, future paid losses on open files will be much less than the present average on closed and paid files. The larger losses have been identified and paid leaving less severe open files to be paid. On the other hand, while a paid neurosurgical file costs an average of $49,373 (graph E-1) the average reserve on open files in $121,196 (graph F-1). These two graphs indicate that the severity *per file* for neurosurgeons, as an example, may be much higher in the future than that of the orthopedic surgeon.





Finally, graph F-2 allocates the anticipated losses, by using current reserves, over the entire insured population by specialty. It eliminates the effect that a few large losses have on the average payment by allocating these reserves over a much larger statistical base and gives a better picture of the specialty as a whole. The most dramatic illustration of this effect is found in the specialty of neurosurgery. The average loss reserve for neurosurgery *per insured* is higher than any other specialty (graph F-2). It also has the highest loss reserve per file (graph F-1). We could conclude the MIIENJ can expect neurosurgery to experience increased severity in the future even though MIIENJ *paid* cases for neurosurgery do not indicate this.

Reserving is an art. The adequacy of reserves is vitally important to the financial solvency of an insurance operation. Thus far, MIIENJ's record has been extraordinarily accurate in reserving. Consequently, the case reserves graphed in E-2 and F-2 should be a very accurate reflection of what MIIENJ and the individual specialties can expect on open files.

The long tail of professional liability insurance must always be kept in mind. It represents hundreds of occurrences that have not yet been reported. Reserving for this exposure referred to as "Incurred But Not Reported" (IBNR) is principally the domain of the actuary.

SUMMARY

The Exchange now has reached the point where information produced by its own record-keeping methods has started to show variations from preexisting New Jersey patterns. In each area, the evidence is supportive of the claim-handling methods established. The timing of the impact on the rates, however, remains to be determined. Should frequencies level off as expected and average claim values also plateau, the leadership will have a prompt indicator. In past years, the insurers of New Jersey Professional Liability were unable to respond to such changes without considerable delay. Many of the details now observed were unavailable. The end product of this vastly improved management information will be better control of the process, and more accurate understanding of costs.

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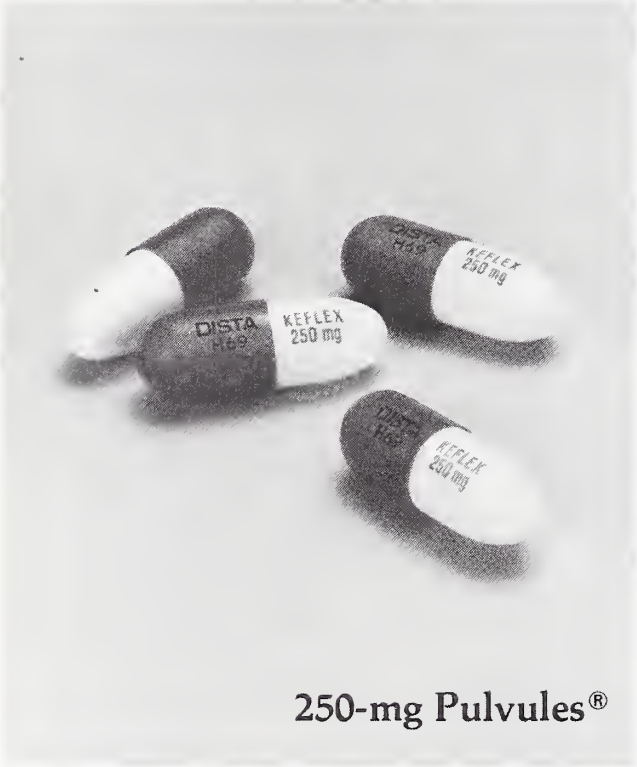

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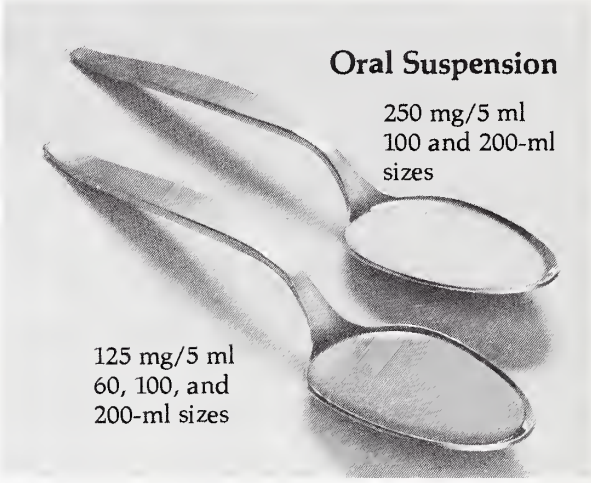

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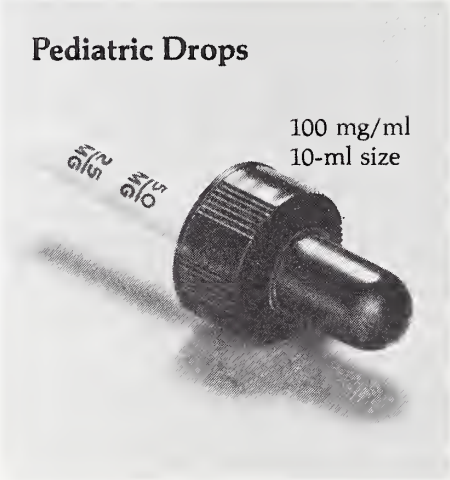

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EDITORIALS

Season's Greetings

The years seem to roll by more rapidly and each day is like the blink of an eye. We all are so busy, so preoccupied and so concerned about local, state, national and international affairs!

Once again, we are coming upon the religious holiday season of Christmas and Hanukkah. In behalf of the editorial board and the staff of *The Journal,* we wish our readers the best of all good things—health and happiness—and a productive professional life.

A.K.

Informative and Provocative

In a letter to the Editor, a physician from Israel referred to our *Journal* as "informative and provocative" (see page 928, this issue). We take this as a supreme compliment.

Editorials, which are regular features of this and most other scientific publications, tend to be of two types—an expression of opinion concerning a topic of general interest or a commentary of a scientific nature which refers to the content of an accompanying article. The subjects covered are wide-ranging, from AMA membership to x-ray costs and all points in between.

The general purpose of an editorial is to stir the reader to consider a point of view which may vary from his own or which has not occurred to him in the past. A good editorial can be considered to be "provocative" if it makes the reader *think* and it is successful if it stirs him to discuss the topic with others and to take pen in hand and write a letter to *The Journal* (even one which expresses a contrary opinion) or to someone else (e.g., a New Jersey Senator or Congressman).

The essence of an editorial is the fact that it represents a personal opinion of the author and in that sense, of necessity, it need not be a self-evident truth which can be verified by scientific scrutiny. As indicated in the complete "Information for Readers and Contributors," which is published each year in the January issue, editorial content is the sole responsibility of the author. It *does not* represent an official position of *The Journal,* the Publication Committee, the editorial staff, the Medical Society of New Jersey, or the officers and Board of Trustees of MSNJ.

Editorials solely express the opinion of their authors and the content generally is restricted only by legal implications and the bounds of good taste. Thus, the material contained therein is not subjected to prior scrutiny by anyone, especially by those who may hold contrary opinions. To do this would constitute censorship and a breach of editorial freedom which should be unacceptable to all Americans—especially to physicians and academicians.

One of the features of this *Journal* over the past year has been a series of articles prepared by New Jersey Senators and Congressmen. These were written at the request of your Editor. The only suggestion as to topics was that our national representative write on a subject of interest to physicians. They need not deal with health per se—although many discuss health legislation. The purpose of this series was to allow our readers to hear it "from the horse's mouth." We did not anticipate that elected officials could write an article for a medical journal whose ideas would be wholly acceptable to all of us. Thus, we expected these statements to provoke some readers—and so they have. In one sense, then, these brief papers have been both successful and provocative.

Letters to the editor of this *Journal* are encouraged. Like editorials, they represent the opinion of their authors. Freedom of expression here is once more limited only by the bounds of good taste and the potential for legal entanglements.

Radio commentators live in mortal fear that there is no one listening. Likewise, editors and publishers are apprehensive that no one is reading their printed material. Letters to the Editor, even critical and hostile ones, indicate that someone is reading and is stirred up enough to express an opinion in writing.

If this *Journal* has been "informative and provocative" to a Family Practice Journal Club in Israel, we are pleased. If it proves to be the same for readers in New Jersey, we are moving in the right direction.

A.K.

Spencer T. Snedecor, M.D.—1900-1980

Spencer T. Snedecor, M.D., 144th President of the Medical Society of New Jersey, died on Saturday, August 23, 1980, in Memphis, Tennessee. Dr. Snedecor was the youngest man ever to have held the office of President, and at the time of his death was the senior surviving Fellow.

Spencer Treadwell Snedecor was born in Blue Point, New York, on February 24, 1900. He graduated from Dartmouth College in 1920, and from Columbia University College of Physicians and Surgeons in 1923. He developed a strong interest in surgery, and particularly orthopaedic surgery, and later founded the Department of Orthopaedics at Hackensack Hospital. He was Chairman of this department, and remained a part of it for all of his professional life. Dr. Snedecor was practicing orthopaedics long before there was an American Board of Orthopaedic Surgery. Although he was therefore never "certified" by this Board, his skills and abilities as an orthopaedic surgeon were certified by the respect and honor he was accorded by his fellow orthopaedists. He was elected to honorary membership in the New Jersey Orthopaedic Society in 1959, and was the only "non-boarded" orthopaedist ever to receive this honor.

Perhaps best known for his work in evaluation and classification of emergency departments, Dr. Snedecor became Chairman of the Emergency Department Committee of the American College of Surgeons—New Jersey Chapter in 1956. In 1968 he became Chairman of the Emergency Room —Trauma Committee of the American College of Surgeons. His efforts in improving and upgrading emergency services were nationally recognized.

For many years, he spent his vacations at missionary hospitals around the world. He served as Chairman of the Christian Medical Council of the National Council of Churches, and also as President of the World Overseas Ministry of the Reformed Church of America.

Spencer Snedecor had served in the United States Navy, before he was a physician, in World War I. During World War II he again entered the service of this country, and served in the U.S. Army Medical Corps from 1942 through 1945, attaining the rank of Lieutenant Colonel.

He continued to practice until he was 75 years old, caring for his patients, teaching young physicians, and serving the medical profession and the people of New Jersey. He once said:

"Medicine is the same all over the world. It is the care of the sick and the prevention of illness. Its appeal is universal. Doctors are the same in every country. They have the same philosophy and practice within the framework of their education. There seems to be a somewhat new philosophy coming along, but doctors basically treat patients to be of help. That is what is most rewarding—it has to be."

The Spencer T. Snedecor Trauma Oration, a permanent part of the MSNJ Annual Meeting, remains as a tribute to the man and his interests. His work and his ideals stand also as a memorial to his life.

He is survived by his wife, the former Mary Overton, a daughter, Jeanne S. Packet, a son, Spencer T. Jr., and five grandchildren.

Paul J. Hirsch, M.D.

Congratulations, Max

Max M. Novich, M.D., an orthopedic surgeon and specialist in sports medicine, recently was selected as an Honorary Member of the World Boxing Hall of Fame. A member of the AMA, the Medical Society of New Jersey and the Essex County Medical Society, Dr. Novich also was honored by the City of Perth Amboy, whose mayor, George J. Otlowski, designated October 25, 1980 as "Dr. Max M. Novich Day," and by the Pulaski Citizens Club (see details, page 924, this issue).

The recipient of numerous honors and awards, Dr. Novich has shown that one can practice medicine and make major contributions in another field for the benefit of the local, national and international community.

Max Novich is to be congratulated by his colleagues for his efforts in behalf of young people. A.K.

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REDISTRIBUTION OF HOUSE SEATS

A proposal to prohibit use of 1980 census figures for redistributing House seats was approved (222-189) by the House. Chief sponsor of the bill, Representative Joseph McDade (R-PA) argued that the census tabulations included some 20 million aliens, both legal and illegal. He held that they should not be counted for purposes of Congressional representation.

The proposal has had a $9.7 billion appropriation bill added as an amendment to benefit the Treasury Department, Postal Service, and the Executive Office of the President. It has been approved by the Senate Appropriations Committee and now is pending before the Senate.

Should the legislation be enacted, the present apportionment, based on 1970 census figures, would continue through the 1990 election. This would result in the suspension, for a decade, of the continuing shift of political power from the northern industrial states to the fast-growing states in the south, southwest, and far west.

New Jersey would retain its present 15 House seats only if this legislation is enacted, otherwise New Jersey would lose 1 House seat due to the 1980 census.

The following table indicates the projected changes in state delegations to the House of Representatives based on the results of the 1980 census.

State	Present	Change
Florida	15	+3
California	43	+2
Texas	24	+2
Arizona	4	+1
Colorado	5	+1
New Mexico	2	+1
Oregon	4	+1
Tennessee	8	+1
Utah	2	+1
Washington	7	+1
New York	39	−4
Illinois	24	−2
Ohio	23	−2
Pennsylvania	25	−2
Massachusetts	12	−1
Michigan	19	−1
New Jersey	15	−1
South Dakota	2	−1

A LESSON TO BE LEARNED

A recent mailing from MSNJ to its membership entitled, *Our 10 Worst Mistakes,* concerned itself with Canada's socialized medicine. The list was developed by Raymond Robillard, M.D., a Montreal neurosurgeon, and presented to the Association of American Physicians and Surgeons at its 1979 Annual Meeting. Of the "10 mistakes" presented, three are directly related to "political action," or in this instance "the lack of" political action.

Lack of political insight left the medical profession completely isolated from the public when the crunch came.

—We simply lacked unity to save individual liberty and responsiblility.

—The Canadian medical profession failed to recognize the political nature of the problem until it was too late.

AMPAC-JEMPAC-IMPACT

A recent article entitled "AMPAC's IMPACT" by Jeffery Cohn appeared in the September 1980 issue of *The Internist.* Mr. Cohn presented an objective view of AMPAC and its impact on the political process. Many of the salient points presented regarding the rationale for AMPAC's existence easily can be adjusted to include the rationale for the existence of state PACs.

- AMPAC/JEMPAC provides physicians the needed voice to help shape legislation that affects them and their patients.
- AMPAC/JEMPAC is not interested in bugging candidates. "That's counterproductive. We just want them to listen to our point of view."
- AMPAC/JEMPAC encourages physicians to participate in the political process.
- AMPAC/JEMPAC supports good legislators rather than choosing by party label or political philosophy.
- AMPAC/JEMPAC provides more clout as an organization than can the individual physician working alone.
- AMPAC/JEMPAC can assist in having legislators understand complex medical issues and develop a positive relationship between physicians and legislators.

JEMPAC DEVELOPS STATE LEGISLATIVE HOTLINE

A JEMPAC membership "State Legislative Hotline," consisting of 400 physicians, has been developed to assist in communicating with State Legislators on proposed legislation. The "Hotline" does not replace our "keyman" system, but serves as another means of presenting a united voice.

The "Hotline" is implemented only when proposed legislation needs impact. When the system is implemented, physicians are contacted by JEMPAC and informed as to the number of the proposed legislation, MSNJ's stand and rationale of such a stand. The physicians then are requested to contact the legislator in their voting district. In many instances physicians are responsible for contacting other physicians to elicit their assistance in contacting a legislator.

MSNJ's POSITION ON PROPOSED NJ LEGISLATION

Assembly-771—Thomas J. Deverin, (21st District, parts of Union and Middlesex). To require law enforcement officers, when arresting a person not in control of his physical functions, to determine whether the person is wearing a medical alert device specifically delineating a medical disability and to require immediate medical aid. **APPROVED**
Referred to:

Judiciary, Law, Public Safety and Defense Committee:

Martin A. Herman, Chairman, William J. Bate, Vice Chairman, John Paul Doyle, Eugene J. Thompson, William E. Dowd, William L. Gormley, Walter M.D. Kern, Jr.

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*Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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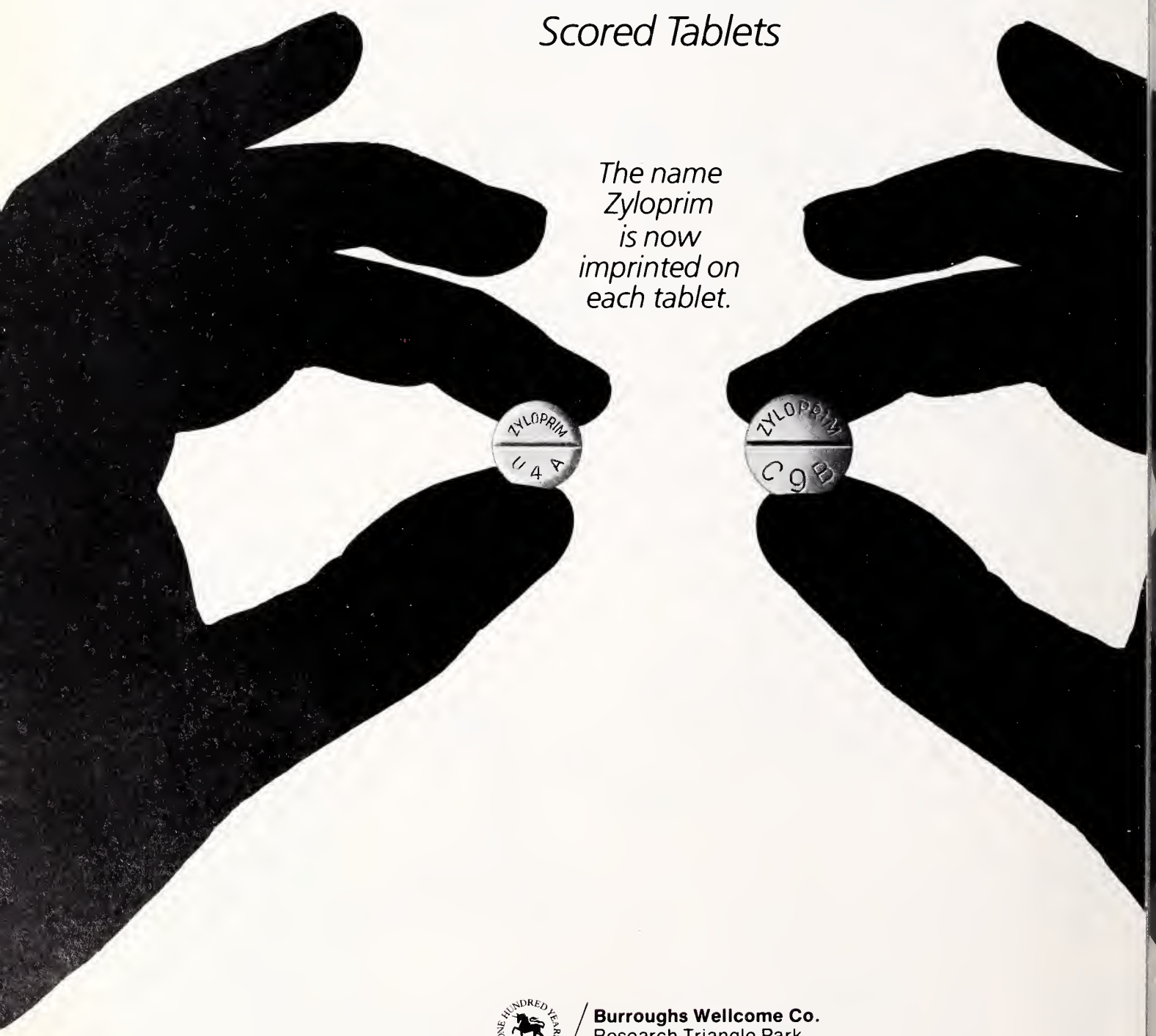

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Removal of Unnecessary Pacemakers*

D. MORSE, M.D., A. PATEL, M.D., A. GOOCH, M.D.,
R.S. CUASAY, M.D., G.M. LEMOLE, M.D., Browns Mills

Two patients with "permanent" implanted pacemakers had their pacemakers permanently removed. Two others were studied with this in mind, but removal was not indicated. The patients were studied by electrocardiograms, Holter monitoring, repeated telephone electrocardiogram transmissions, overdriving and reprogramming of their pacemakers. Telephone and other monitoring was continued after removal of the pacemakers. The studies mentioned serve to indicate who is a candidate for possible permanent removal. The extended range rate-programmable pacemaker is presented as a valuable tool in increasing the safety of permanent removal.

Pacemaker therapy is an important advance in improving both the management and the longevity of patients. There are increasing indications for pacemaker insertion; approximately 150,000 pacemakers are implanted annually in the United States. Only recently have there been any reported cases[1,2] of successful permanent explantation of a pacemaker although the possibility was mentioned earlier.[3,4] We have had two such cases in whom "permanent" pacemakers were *permanently* removed, as well as unsuccessful attempts made in two other patients.

The purpose of this article is to define the criteria for reaching a decision for permanent removal of a pacemaker, to discuss the risks involved, and to bring this occasionally somewhat troublesome concept of possible permanent removal to the attention of those in the medical profession concerned with pacemaker followup and replacement.

CASE REPORTS

#1—A 37-year-old male was diagnosed as Wolff-Parkinson-White Syndrome Type A in 1962. He continued to experience frequent attacks of tachycardia and seizures despite different anti-arrhythmic agents. The neurological evaluation was negative. Because of the refractoriness of his symptoms despite medical treatment, he underwent open heart surgery and ligation of the atrio-ventricular bundle to achieve complete heart block(s) and had an epicardial permanent pacemaker implanted.[5] The His bundle was cut rather than the anomalous Kent bundle because at that time, 1967, the surgical methods for finding the latter had not been described. Procainamide was continued and the symptoms improved.

By October 1976 he had had eight followup visits since the last replacement of a pacemaker generator in March 1973; on all these occasions he was found to be in normal sinus rhythm. He had a 24-hour Holter monitor study in December, 1976 which revealed normal sinus rhythm with a rare supraventricular extra systole. In August 1977, the telephone monitoring service reported that the pacemaker could not be activated with a magnet. Since the patient was in sinus rhythm, obviously there was some question as to whether or not the patient had a continued need for the pacer. At this time, it was thought prudent not to replace the unit, but to leave the defunct pacemaker in place.

The strategy depended on the fact that the patient eventually would require an operation to remove the pacemaker. This operation could be deferred, however, until it was apparent whether it should be only a removal, or a removal and replacement. This patient was followed closely clinically and by the telephone monitoring service. On evaluation in January 1978, and during the interim, he had had no arrhythmias and was clinically stable, therefore, *the*

*From the Deborah Heart and Lung Center, Browns Mills, New Jersey. Correspondence may be addressed to Dr. Morse, The Deborah Heart and Lung Center, Trenton Road, Browns Mills, New Jersey 08015.

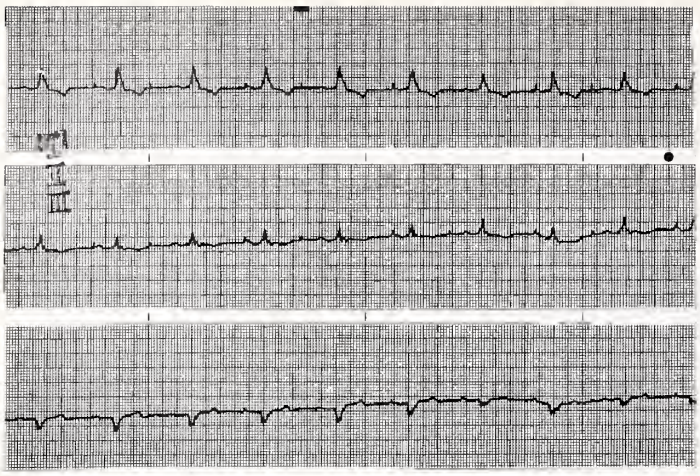

Figure 1—This electrocardiogram shows complete failure of both sensing and pacing. The patient's rate is 75-80.

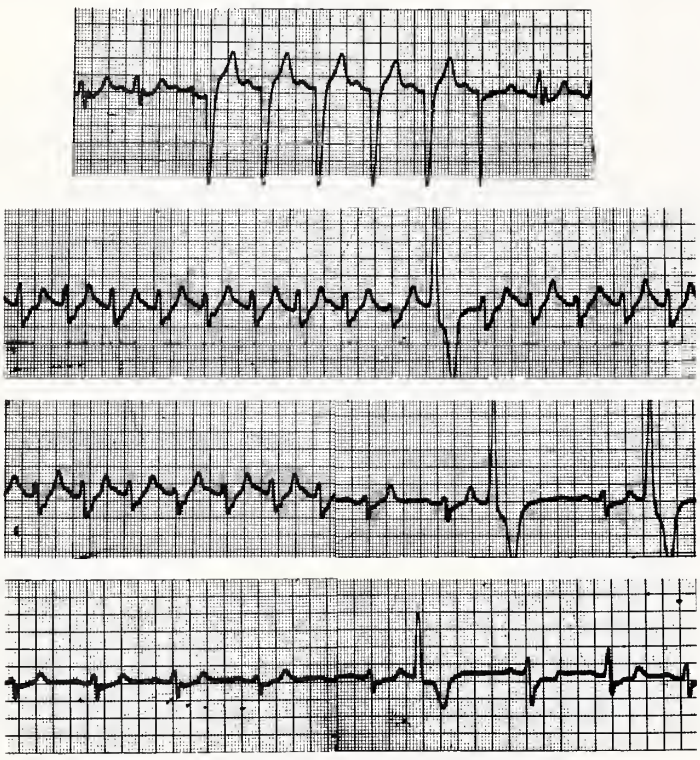

Figure 2—Electrocardiograms taken during treadmill exercise test show heart rate increase from 65 to 110 beats per minute (In the first strip there are different leads). The subsequent sections show sinus tachycardia with more aberration and extra systoles.

pacemaker generator was removed from his left shoulder pocket and the electrode was capped. Procainamide was continued postoperatively. At his last followup in October 1979 he was asymptomatic and continued to show no need for a pacemaker.

#2—A 71-year-old male had a pacemaker inserted in November, 1970 (at another hospital) for sinus bradycardia, left bundle branch block, and premature ventricular contractions. He also had angina pectoris. In February 1977, he was hospitalized at the Deborah Heart and Lung Center for "pacemaker failure." The patient denied angina and syncopal attacks.

His electrocardiogram showed sinus bradycardia at 55 per minute, first degree atrio-ventricular block and left bundle branch block. The pacemaker was not sensing and there was no capture (Figure 1). During a treadmill exercise test his heart rate increased from 66 to 110 a minute (Figure 2). He also had 24-hour Holter monitoring on two occasions (Figure 3) which revealed sinus rhythm varying from 56-140 per

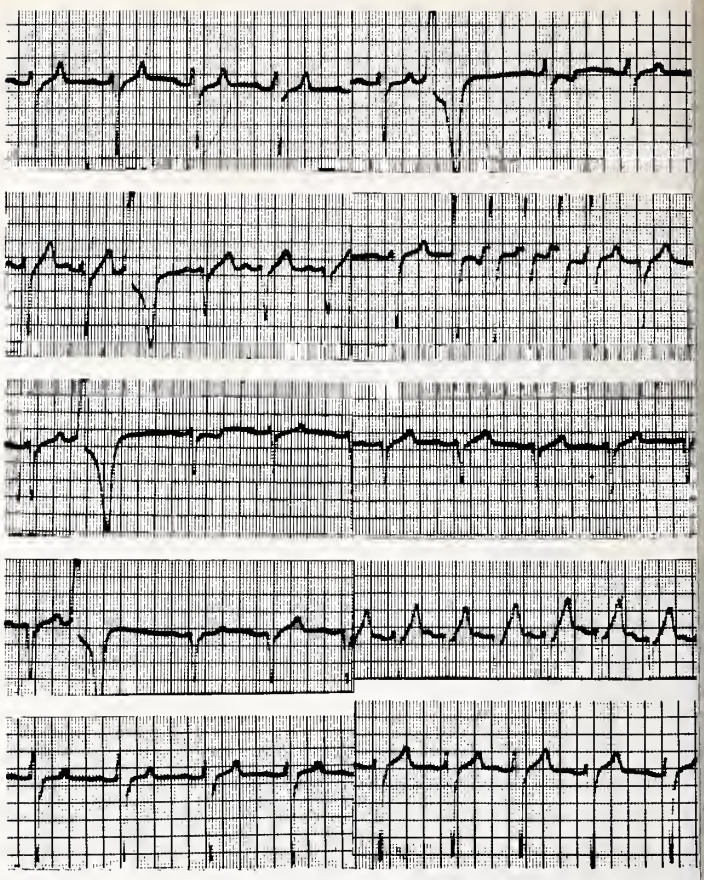

Figure 3—Ten selected electrocardiogram strips from a 24-hour Holter monitor show sinus rhythm varying from 56-140 per minute, a few premature ventricular contractions, and a short run of paroxysmal atrial tachycardia.

minute, a few premature ventricular contractions and a short run of paroxysmal atrial tachycardia.

During the hospital stay his electrocardiogram was continuously monitored and he remained in sinus rhythm. In February, 1977 the pacemaker was removed. Following removal he was seen repeatedly in the pacemaker clinic and monitored by telephone. In January, 1979, he was stable clinically and his electrocardiogram showed sinus rhythm varying from 50 to 65 beats per minute (Figure 4). He still had left bundle branch block and first degree atrio-ventricular block.

#3—A 61-year-old male, who is known to have rheumatic and coronary artery disease, had a rechargeable pacemaker implanted at another hospital in March 1977 after a subendocardial myocardial infarction complicated by bradycardia. The postoperative course was complicated by staphylococcal infection at the site of pacemaker implantation and also staphylococcal septicemia, which was treated successfully. He was seen at the Deborah Heart and Lung Center for recurrence of smoldering infection at the pacemaker site. Since he was using the pacemaker intermittently, we decided to assess whether or not he was really pacemaker dependent. If he was, he would need a new pacemaker on the other side away from the infection.

We allowed the pacemaker to slow down by not recharging it for eight weeks. He then had a definite episode of lightheadedness and dizziness with bradycardia to 51. His electrocardiogram showed atrial fibrillation and no pacemaker spikes with the magnet (Figure 5). Fortunately, at this time we were able immediately to recharge the pacemaker. Subsequently, he had a new pacemaker system implanted on the other side, and his rechargeable pacemaker, which had served well for diagnosis, was removed.

#4—A 65-year-old male had a pacemaker implanted in

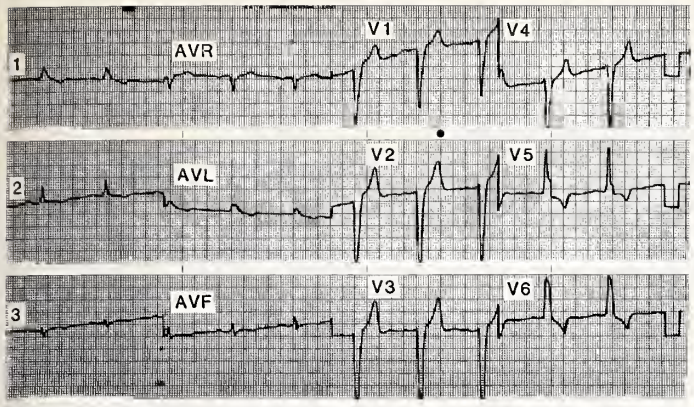

Figure 4—Electrocardiogram shows sinus bradycardia, first degree AV block, complete left bundle branch block, and ST abnormalities (after the pacemaker has been removed).

1964 for acute inferior wall myocardial infarction complicated by complete heart block with a ventricular rate of 40 per minute. When he was admitted to Deborah Heart and Lung Center for replacement of his pacemaker he was found to have atrial fibrillation with a ventricular response of 75 to 82 per minute. His 24-hour-Holter monitor showed occasional pacemaker capture. During a treadmill exercise test his heart rate increased from 70 to 150 per minute; he had a Class I exercise tolerance. At this time we decided *not* to replace his pacemaker. Although his pacemaker failed the following month, the patient remained asymptomatic with a rate of 80. He was put on our telephone pacemaker checking service (three times a week) for transtelephonic electrocardiograms to give additional data points on his rhythm. At this time the pacemaker was completely non-functional.

The patient continued to be asymptomatic. However, because the patient had a *normal* ventricular rate with atrial fibrillation and without digitalis (normally a fast rate would be expected), his cardiologist felt he had an atrio-ventricular conduction defect. This conclusion together with his cardiomegaly and the possible need for digitalis in the future, resulted in a decision for pacemaker replacement, although his own unit had been defunct for several weeks.

DISCUSSION

Some critics have claimed that many pacemakers have been inserted unnecessarily.[6] However, in a pacemaker practice, dating back to 1961 and involving over 2000 patients, we have been able permanently to explant pacemakers from only two patients.[7-11]

Removing a pacemaker and not replacing it may be difficult because it seems either to be contradicting the judgment of the physicians who originally implanted it, or one must assume that the disease of the heart improved and the conduction system returned to more normal function.

Fortunately, there are several established standards which are available to help physicians decide in favor of permanent explantation. The first is, of course, the generally accepted

". . . in a pacemaker practice, dating back to 1961 and involving over 2000 patients, we have been able permanently to explant pacemakers from only two patients."

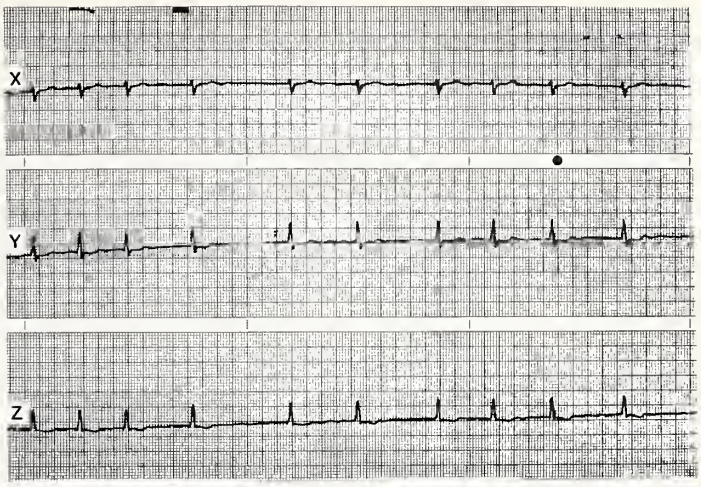

Figure 5—Electrocardiograms taken with a magnet show no pacer artifact. The length of the fourth R-R interval corresponds to a rate of 45. The rechargable pacemaker was recharged ten minutes after this tracing.

indications for implanting pacemakers. Obviously, if it can be established that the patient no longer has any of the usual indications for artificial pacing, removal is reasonable.

Other helpful aids to the decision for permanent explantation are less obvious and some only recently have become available. They can be grouped under the heading of those related to the pacemaker themselves, those relating to testing methods, and those which can result from the use of followup measures including telephonic services and monitoring devices. (See Tables 1 and 2)

Features in pacemakers helpful in considering permanent removal—Rechargeable pacemakers (Pacesetter®) can be slowed in rate by merely not recharging. Such slowing may reveal continuous impulse formation by the patient. However, this feature is impractical to use, since the most desirable rates of 30 to 50 occur close to pacer exhaustion where capture is unreliable. Allowing the pacemaker to become completely exhausted, however, can be a useful technique. This can be a complete test over a period of time of the patient's need for a pacer, while retaining ability to reactivate the pacer by recharging at any time. Thus, this pacer can be removed functionally without an operation and similarly reinstated.

Programmable pacemakers that can be reduced to rates 30 to 50 are perhaps the best devices for testing patient need. With these slow rates the patient's dependence should become obvious if present and yet there is protection against the undesirable effects of asystolic periods. The four leading United States manufacturers now offer rates in the 30 to 50 range in their programmable units (Table 3). A less desirable method of testing for need is programming output, or pulse width to a level below threshold so the pacemaker becomes impotent. The danger of this is obvious: Rate programming can be a partial turnoff with some safety, whereas power (output) programming is an all or none action.[12,13]

"In preparation for removal it is helpful then to have the combination of a programmable pacemaker that can be turned to a low rate (30 to 50 ppm) and evidence of continuous lack of pacer use (by Holter monitor)."

Table 1
Procedures to Test for Pacer Need

1. Put programmable pacer at low basic rates, e.g., 30 to 50 and observe
2. If necessary, replace pacer with programmable unit to accomplish (1) above.
3. Turn off pacer with overdrive at each clinic or office visit and observe rhythm.
4. Check repeatedly by telephone on pacer for 1 to 2 years (Does patient always have his own rhythm faster than the pacer?)
5. Do repeated 24-hour Holter monitor tests and exercise tests for abnormal rhythms.
6. Let pacemaker run down and determine if patient becomes symptomatic. (This is particularly easy and useful in a rechargeable unit which quickly can be recharged to function.)
7. Check the patient with the defunct pacer weekly by telephone for three months for adequacy of rhythm before removing the unit in order to save the patient an operation (see text).

Table 2
Tests Useful in Permanent Pacemaker Explantation

1. Electrocardiograms.
2. Telephone pacemaker followup reports (routine).
3. Stress tests.
4. Holter monitoring.
5. Pacemaker inhibition by overdrive.
6. Pacemaker reprogramming to low rate
7. Pacemaker reprogramming to ineffective output.*
8. Telephone monitoring on a frequent predetermined schedule and patient activitated if symptoms occur after pacer has been allowed to become exhausted.

*Only to be employed as a last step before explantation and after 6 has shown patient always has an effective rate.

Acute testing methods for pacemaker dependency—Exercise testing can be a useful adjunct because rates and rhythm may change with exertion; this further demonstrates the range of clinical challenges which may have relevance to a possible need for pacing. Treadmill tests for such patients are safe if exercise levels are limited to easily tolerated walking (in this sense, such testing is not appropriately termed "stress."[14]

Overdrive with two electrodes on the chest[15] will inhibit the internal pacemaker and provide a revelation of underlying rhythm for as long as the overdrive is continued. This test is, of course, inadequate, or only a first step in a program of considering possible pacemaker removal.

Followup methods to determine minimal pacer dependency—Holter monitoring (see Figure 4) for 24 to 72 hours can be supplemented by a telephone service in which the patient's electrocardiogram is recorded. This can be done according to a three-times-a-week schedule and supplemented by immediate call-in and record of the rhythm when the patient has minimal symptoms. The telephonic pacemaker checking equipment and services are ideal for this purpose.

In preparation for removal it is helpful then to have the combination of a programmable pacemaker that can be turned to a low rate (30 to 50 ppm) and evidence of continuous lack of pacer use (by Holter Monitor). This can be supplemented by intermittent evidence over one to two years, for instance from a telephone pacer checking service, that he is "on his own" whenever the patient calls in (no pacemaker artifacts).

"When the implanted pacemaker is removed, the question arises as to whether to remove the lead . . . we feel strongly that the lead should be left in place—it always can be removed later if troublesome in some way."

Table 3
*Commonly Used Programmable Pacemakers With Rates 30 to 50**

	Low Rate Limit
Cardiac Pacemakers Inc. Models 505, 506 "Microlith P"	30
Cordis 190E, F (Lambda)	50
237 (Theta)	25
Intermedics 251, 252	51
"Interlith RP" Lyberlith	30
Medtronics 5994, 5995 "Xyrel VP", Spectrax	30

*Programmable units from almost all the other manufacturers, some now in the validation process, include models with comparable low rates. Please refer directly to each company for further information.

REMOVAL PROCEDURE

The pacemaker—Whenever it is contemplated that a pacemaker be removed permanently, we strongly advocate the following procedure. First, replace the pacemaker with a programmable unit that can be set at a very low rate limit (30 bpm). This unit will show whether the patient ever needs backup support, and will maintain the patient's safety.

The lead—When the implanted pacemaker is removed, the question arises as to whether to remove the lead. There is an obvious argument that if the patient does not need the pacemaker, why leave the lead? However, we feel strongly that the lead should be left in place—it always can be removed later if troublesome in some way. Leads in the past have been innocuous as far as cardiac function is concerned. Removal of the previous pacing system one step at a time seems best. Years later the patient may develop similar or different problems and require pacing. A proven lead is a considerable advantage when pacing does need to be reinstituted, since there is a three to fifteen percent incidence of lead dislodgment and other problems in new transvenous systems.

Removal of old epicardial or screw-in myocardial electrodes is a major operation with a definite although minimal mortality and morbidity. The lead system that is left in place should be capped properly and sealed to prevent corrosion and deterioration of the wire. The end should be buried deeply under the skin so there will be no possibility of it turning up toward the skin and eroding through.

SUMMARY

An increasing number of pacemakers are being inserted each year in the United States. It is likely that some of them should be merely removed and not replaced when they become exhausted. Two case studies in which permanent removal was possible are presented together with the indications, methods of study and technical aids which make a decision for removal possible. One patient had had open

heart surgery for WPW syndrome and the other had had sinus bradycardia, left bundle branch block and premature ventricular contractions. Two other patients are described in which permanent removal was not possible. Methods of testing pacemaker need include overdrive, programming to low rates, exercise testing, and Holter and telephone monitoring. Conservative surgical maneuvers include leaving the exhausted pacemaker in place for some weeks before removing the pulse generator, and leaving the transvenous lead in place even after the former is removed.

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FREE DEMONSTRATION WITH ABSOLUTELY NO OBLIGATION

Clinical Usefulness of Computerized Tomography of the Thorax*

ALBERT D. CARILLI, M.D., GEORGE OEN, M.D.,
JOEL BUDIN, M.D., ROBERT KRUGMAN, M.D. Hackensack

CT scans of the chest of sevety-five patients were reviewed. The role of CT in the evaluation and management of chest lesions was assessed. CT was found to be particularly useful in characterizing parenchymal lesions, in distinguishing pleural and mediastinal pathology and for the detection of pulmonary nodules. Illustrative cases are presented.

Computerized tomography (CT) became available less than seven years ago.[1] Within the brief period since its inception, CT has had a dramatic impact on the practice of medicine. This was seen particularly in the fields of neurology and neurosurgery, where diagnosis and management have been revolutionized.[2,3] Anatomic detail and pathology is visualized in a manner hitherto unattainable.

Shortly after its acceptance as a standard diagnostic procedure in the clinical neurosciences, CT was applied to other areas of the body with the development of a general purpose scanner.[4-6] Criteria for its use for other anatomic sites currently are being investigated. In this report we present our preliminary experience with CT of the chest. Its role in diagnosis and management of various pulmonary disorders is assessed.

METHODS AND MATERIALS

CT scans were obtained by an Ohio Delta scanner with a scan time of 2.5 minutes and a slice thickness of one cm. from apex to base averaging 14 to 18 scans per study. The scans were displayed on conventional films with dimensions of 8" x 10". Patients were selected for CT only after all clinical information, conventional roentgenography and tomography were reviewed. It was not used as a routine screening procedure. The information derived from CT then was categorized.

RESULTS

Seventy-five patients were subjected to CT of the chest; forty-six were males and twenty-nine females with an age range of 17 to 88 years and a mean age of 55.5 years. Table 1 lists the major diagnoses. In Table 2 the patients are categorized according to CT's role in diagnosis and management. The normal CT scans include two patients with carcinoma of the esophagus, one with a questionable paravertebral mass, one with Horner's syndrome and two with pulmonary fibrosis. The categories listed may be considered potentional indications for CT of the chest. Illustrative cases follow.

Case 1—A 76-year-old male was admitted to Hackensack Hospital with cough, hemoptysis, weight loss and dyspnea. The chest films showed an irregular suprahilar mass, infiltrating the right upper lobe (Figure 1 a, b). Sputum cytology was negative for malignant cells. Fiberoptic bronchoscopy revealed a large fungating mass almost occluding the right main stem bronchus. Biopsy of the mass showed poorly differentiated squamous cell carcinoma. CT of the

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Table 1
Diagnosis in Seventy-Five patients Undergoing CT of the Chest

1.	Carcinoma of the lung	25
2.	Lymphoma	8
3.	Vertebral lesion	8
4.	Pneumonia	9
5.	Esophageal carcinoma, radiotherapy follow up	4
6.	Lung metastases	4
7.	Lung abscess	2
8.	Pericardial cyst	2
9.	Lipoma	2
10.	Sarcoidosis	1
11.	Thyroid carcinoma	1
12.	Tumor of the pleura	2
13.	Pulmonary fibrosis	2
14.	Unknown	5

Table 2
The Role of CT in Diagnosis and Management of Chest Lesions

1.	Distinguish chest wall involvement by pulmonary mass (18 without, 5 with)	23
2.	Characterize parenchymal lesions (infiltrative, nodular, cavitary or cystic)	9
3.	Detect vertebral pathology	8
4.	Distinguish pleural density, effusion or parenchymal mass	9
5.	Distinguish mediastinal pathology	8
6.	Distinguish pulmonary mass by density number (lipoma, fluid, hematoma)	4
7.	Detect pulmonary nodules	3
8.	Miscellaneous (radiotherapy protocol for carcinoma of esophagus, pericardial effusion)	5
9.	Normal	6

Figure 1 (a), (b)—Right parahilar mass infiltrating right upper lobe (RUL). There is a suggestion of some posterior densities in the RUL.

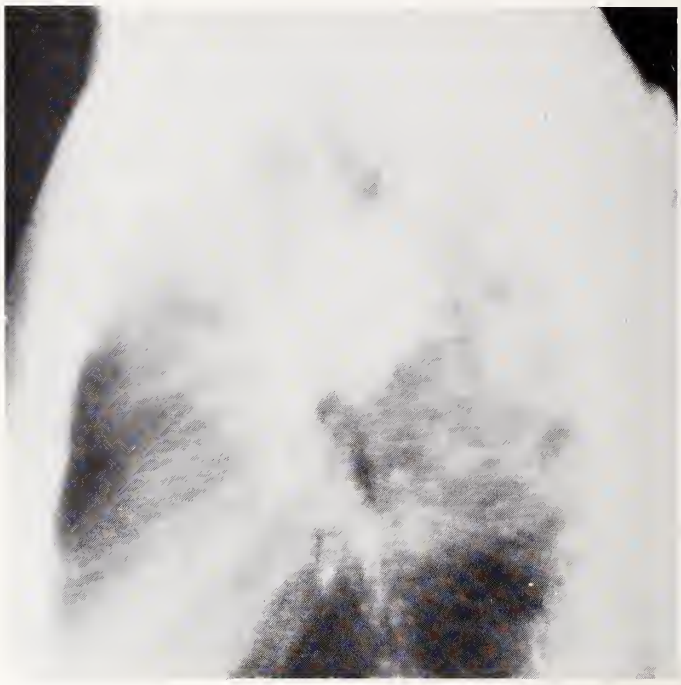


Figure 1(b)

chest showed a right parahilar mass with two distinct nodules in the posterior segment right upper lobe (RUL) and a pleural-based nodule in the left upper lobe (Figure 2, a,b).

Case 2—An asymptomatic 77-year-old female, on routine chest roentgenography, was found to have a rounded density in her left lower lung (Figure 3 a,b). CT showed a homogeneous density, adjacent to the left heart border with a mean density number of −40. This is compatible with a fatty mass (Figure 4).

Case 3—A 64-year-old female was hospitalized because of shortness of breath of three months' duration. The chest films showed a density in the right lower lung and several pleural based densities bilaterally (Figure 5, a,b). Cytologic examination of sputum and pleural fluid were negative for malignant cells. Pleural biopsy was nondiagnostic. Biopsy of a right supraclavicular node revealed lymphocytic lymphoma. CT showed multiple bilateral pleural-based densities with one larger density infiltrating through the right anterior chest wall (Figure 6). Pleural fluid was seen lying posteriorly on the right.

Case 4—A 20-year-old female was admitted to Hackensack Hospital in 1978 because of increasing dyspnea. She was known to have Hodgkin's disease of the nodular sclerosing type, with involvement of the anterior mediastinum. Her treatment included radiotherapy to the mediastinum in 1976 and a MOPP** chemotherapy regimen since February 1978. The chest films showed a diffuse infiltrating process involving the left upper lobe including the lingula. The right diaphragm appeared elevated (Figure 7, a,b). CT showed a density involving the left upper lobe with small bilateral pleural effusions (Figure 8, a,b).

Case 5—A 49-year-old female was found to have a two cm. nodule on her left upper lobe (Figure 9). She was asymptomatic and smoked two packages of cigarettes a day for 25 years. CT of the chest revealed the nodule posterolaterally and a mass in the mediastinum adjacent to the aorta (Figure 10). A thoracotomy proved the latter to be a metastatic deposit in a mediastinal node.

DISCUSSION

A detailed discussion of the general principles and instrumentation involved in computerized tomography is beyond the scope of this presentation. This may be found elsewhere.[4,7] Briefly, in computerized tomography, x-rays are passed through a single cross sectional area of the body from different angles. The x-rays may be attenuated or unaffected as they pass through. Variations in attentuation produced by the different densities of tissue within the cross sectional area or slice are recorded by scintillation detectors or ionizing chambers. The data obtained in this manner are stored,

**Nitrogen mustard, vincristine (Oncovin®), procarbazine, prednisone.

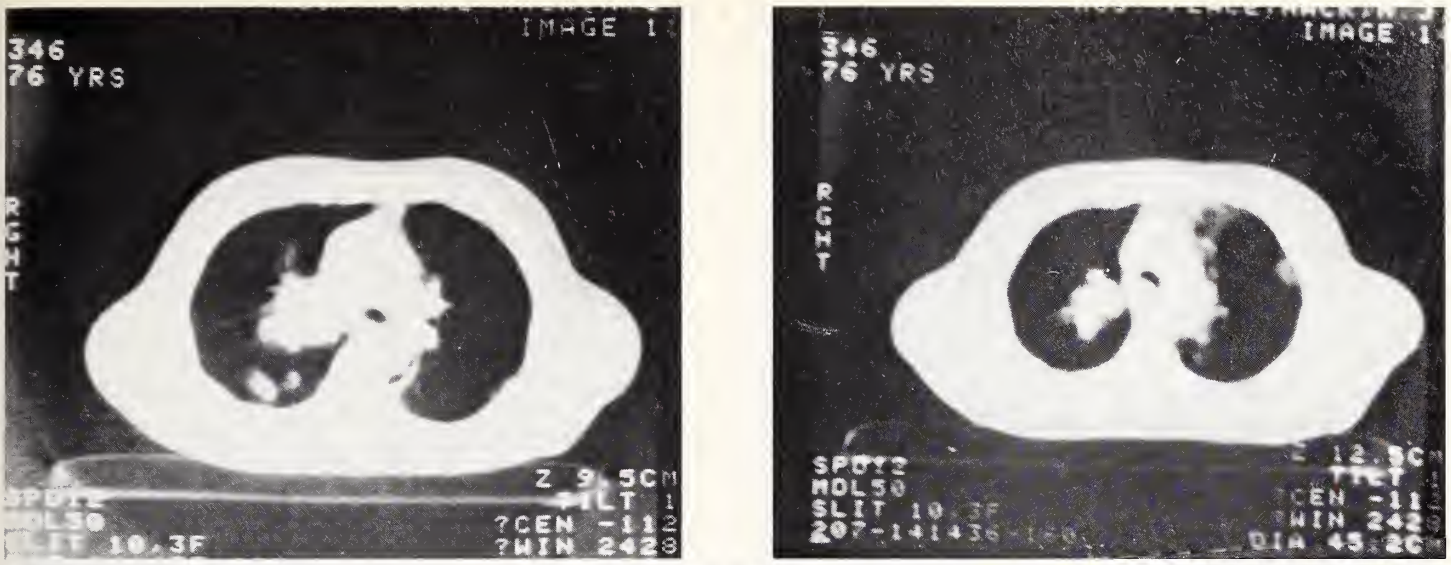


Figure 2 (a), (b)—In addition to the right hilar mass two distinct densities are seen in the posterior segment of RUL (b) left pleural based nodule is clearly seen.

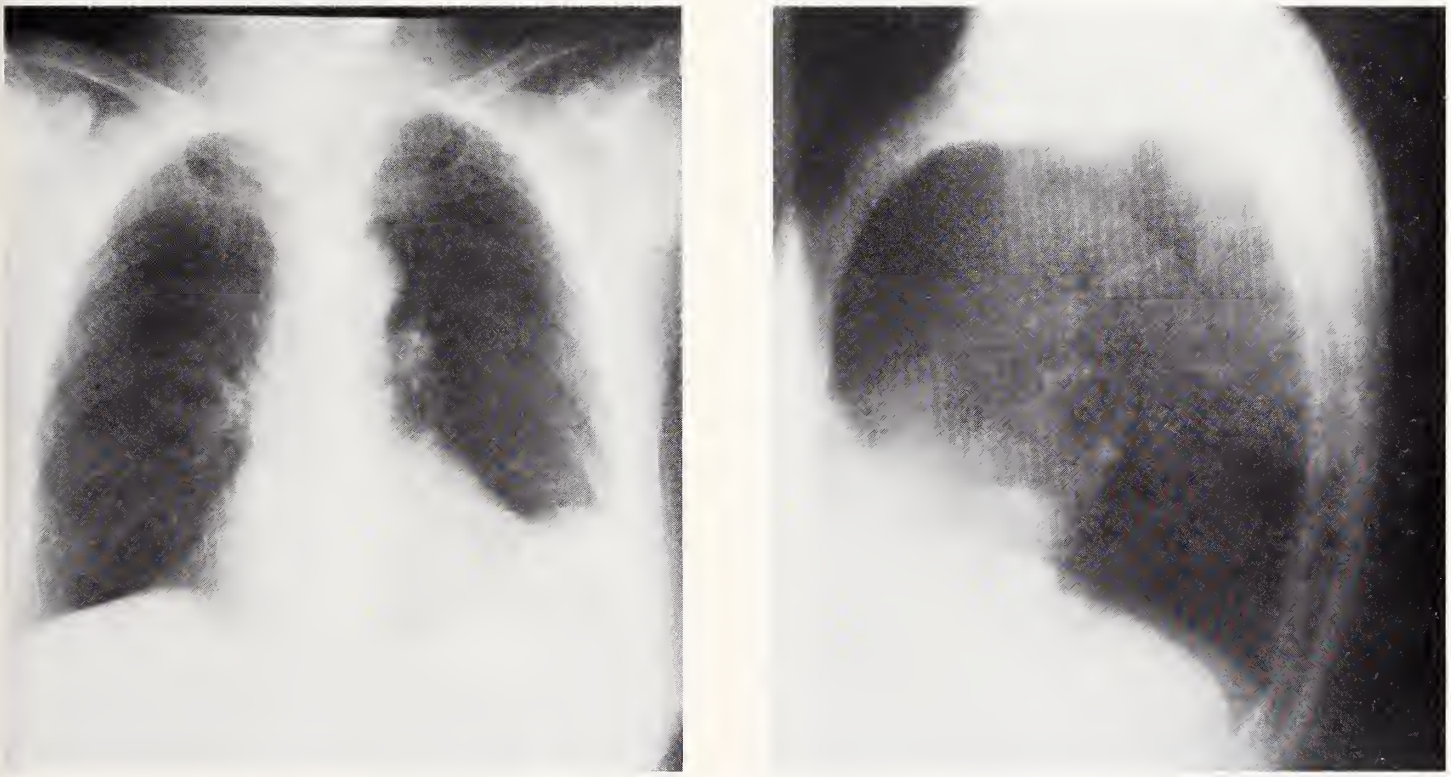


Figure 3 (a), (b)—A rounded smooth density is seen in the right lower lung field adjacent to the heart.

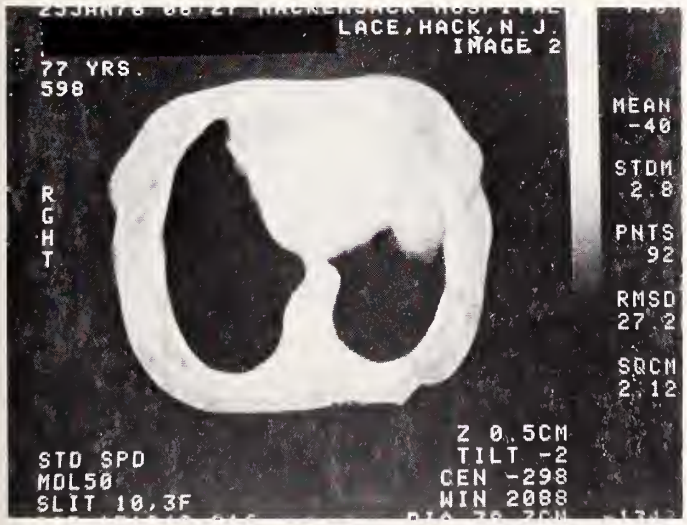
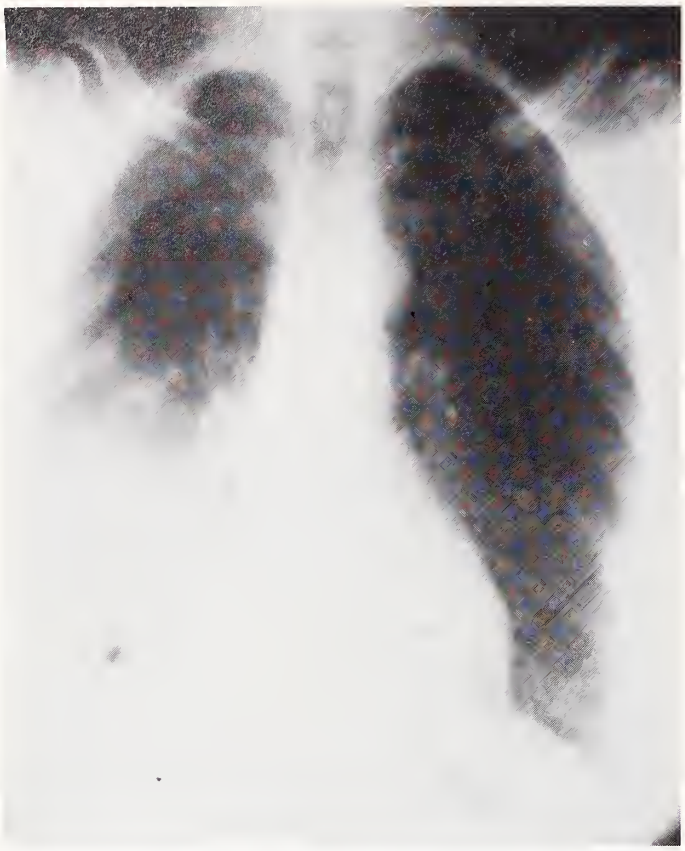


Figure 4—A homogeneous density is seen adjacent to the left heart border. The diamond-shaped marker identifies the area from which the mean density number of −40 was obtained.

computerized and transformed into an image. The image is displayed on an oscilloscope recorder and photographed. Attenuation numbers may be obtained from all areas of the image. Newer machines have been developed with scanning times as short as two seconds. With our long scan time, we were concerned that the quality of the images would not be satisfactory because of loss of resolution due to cardiac and respiratory motion. However, we found the image quality more than adequate for analysis.

There are particular advantages of CT over more conventional means of imaging. A dramatic new perspective of normal anatomy and pathology is obtained noninvasively. Conventional radiographic techniques distinguish differences in tissue densities in the range of five to ten percent. CT distinguishes differences as small as 0.5 percent.[8] Various tissues will have characteristic attenuation numbers which serve as a basis for their discrimination.

From our experience and the experience of others, potential indications have emerged for the application of CT to the



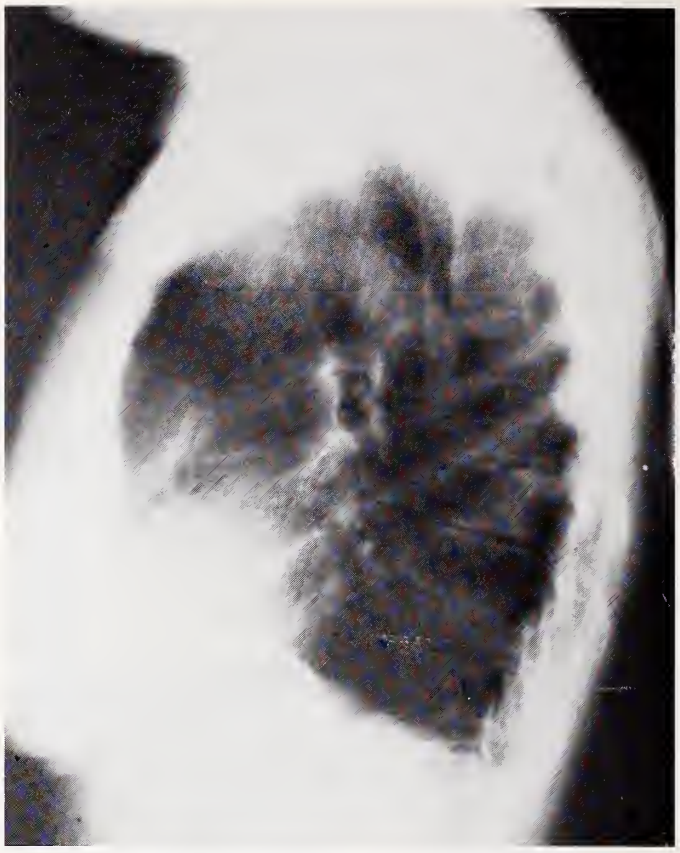


Figure 5 (a), (b)—A density is seen in the right lower lung field with bilateral pleural based densities.

Figure 6—Anterior pleural density infiltrates through the right anterior chest wall. The posterior density on the right is pleural fluid.

chest. It provides another means for characterizing the nature of a lung lesion. It can distinguish whether a lesion is infiltrative or well circumscribed and whether it contains calcium. Single or multiloculated cavities are vividly demonstrated. CT provides information regarding the extent and size of the pathologic process. A lung lesion may be seen to infiltrate through the chest wall to involve the soft tissues and bony structures directly. Cystic lesions such as pericardial or bronchogenic cysts may be distinguished from solid tumors. CT is particularly useful in delineating the nature of pleural densities. It may distinguish a pleural density from loculated pleural effusion or a solid parenchymal lesion. Small accumulations of pleural fluid may be found which are not seen on the plain film.

Precise localization of the pathologic process in relationship to the chest wall is possible. This will assist in percutaneous needle biopsy, in developing radiotherapy treatment protocols and in post-treatment followup.[9]

CT should assume a major role in the search for pulmonary metastasis or nodules. It now is recognized that CT is more accurate in detecting pulmonary nodules than routine roentgenography or tomography. Single, multiple or bilateral nodules may be detected with greater frequency, particularly when they are located in the periphery of the lung. Muhm *et al.* were able to detect nodules in the lungs of two of the six patients with malignant cells in their sputum and negative chest films.[10] CT criteria for benign or malignant pulmonary nodules have been established. A clearer picture of perinodular texture of fibrosis or satellite nodules is obtained. High density numbers indicating intranodular calcification may be determined.[11]

Schaner *et al.*, in a radiologic-pathologic study of metastases from a variety of sarcomas and melanomas using an 18-second scanner, found computerized tomography a highly sensitve method for detecting three to six mm pleural and subpleural nodules.[12] It was of specific value in detecting additional unilateral and bilateral nodules not identified by conventional tomography. They also claimed that CT is mainly limited in its detection of pulmonary nodules because it is overly sensitive and detects three to six mm nodules which prove to be benign at thoracotomy.

CT of the thorax may have its greatest value in detecting mediastinal abnormality or involvement.[13] A horizontal cross-sectional image is superior in detecting pathology often hidden by the sternum, heart, vascular structures or spine. Certain mediastinal lesions can be diagnosed by their tissue composition. Solid masses can be distinguished from vascular structures with the use of intravascular contrast agents. Anterior and posterior mediastinal nodes are visualized along with mediastinal widening and compression of main stem bronchi.[14] On the other hand Underwood *et al.* found five of 18 patients to have tumor involvement at

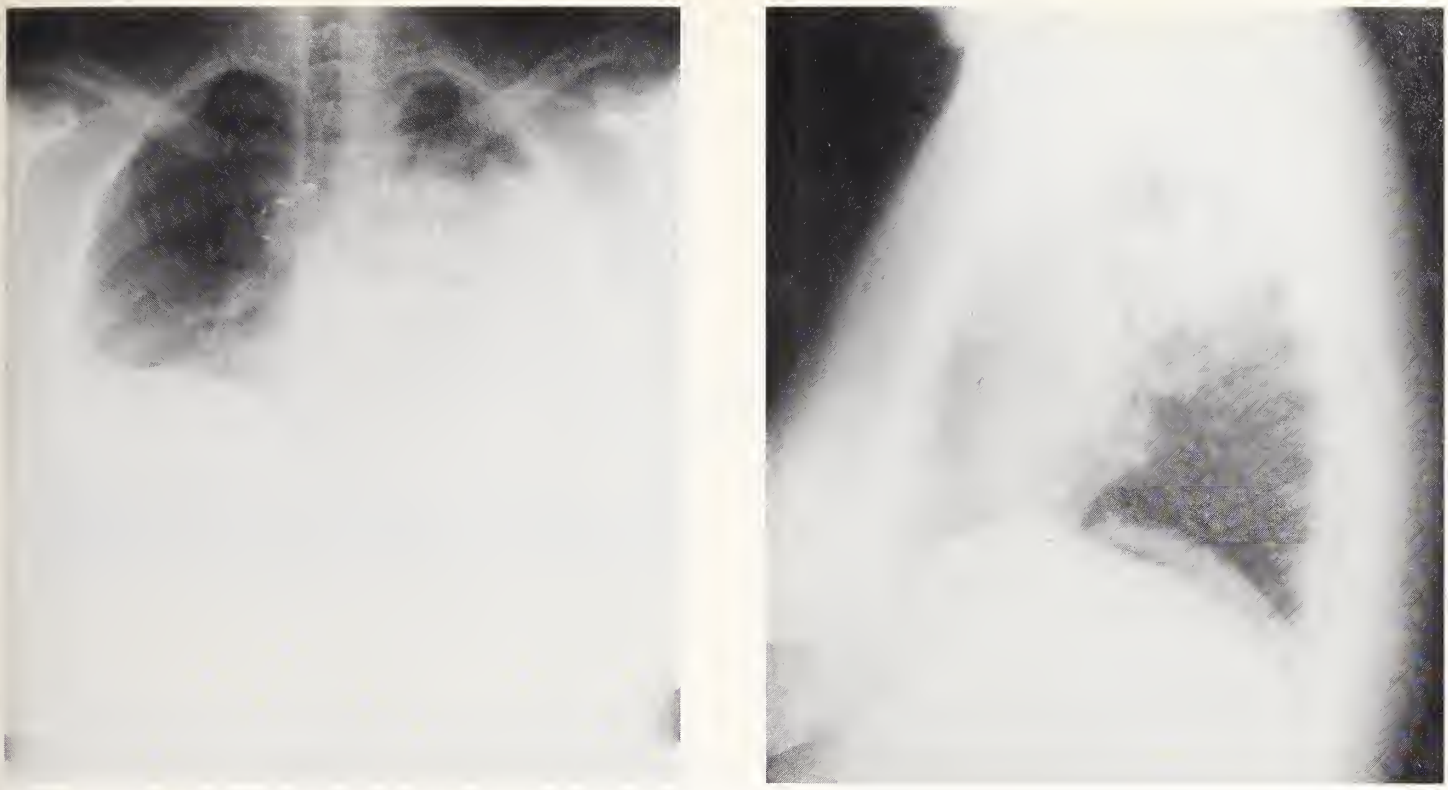


Figure 7 (a), (b)—A homogeneous density is seen throughout the left upper lobe. The right diaphragm appears elevated.

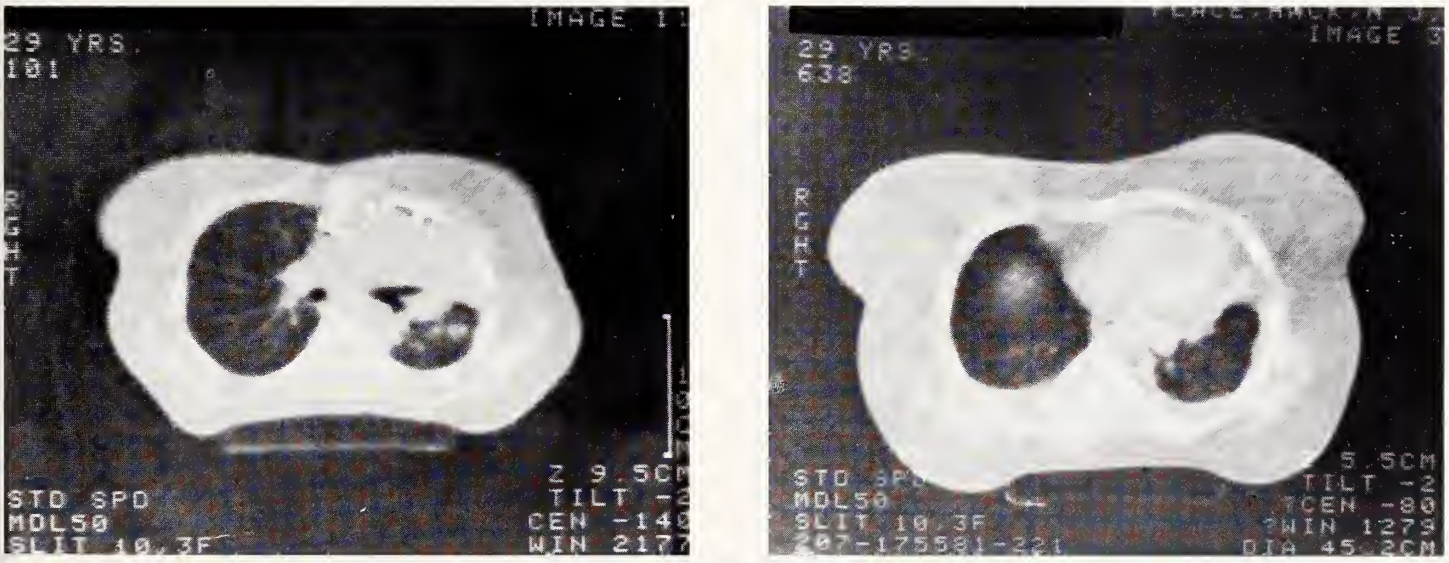


Figure 8 (a), (b)—In addition to the upper lobe density (a), pleural effusions are present bilaterally (b).

mediastinoscopy, where CT scans were negative.[15] They concluded that CT of the thorax should not replace definitive staging techniques for bronchogenic carcinoma.

CT imaging is also useful in studying the character of dissecting aortic aneurysms.[16] Finally it may have application in assessing the degree of parenchymal disruption that occurs with emphysema and interstitial lung disease.[4] This might be aided by contrast enhancement. Correlation of anatomical disease with pulmonary function tests may be possible *in vivo*.

SUMMARY

Computerized tomography has had a dramatic impact on diagnosis and management in the neurosciences as well as in other areas of medicine. Its usefulness in the evaluation and management of chest lesions is currently under investigation. Seventy-five patients were evaluated with the use of an Ohio Delta scanner with a scan time of 2.5 minutes. The major diagnostic categories included carcinoma of the lung, pneumonia, lymphoma, lung metastasis, pleural disease and lung abscess. Chest CT was found most useful for characterizing parenchymal lesions, for distinguishing pleural and mediastinal pathology and for the detection of pulmonary nodules. The information obtained by CT of the chest played a major role in the clinical management of these patients. The quality of the images was more than satisfactory, despite our slow scan time. Undoubtedly, the new fast scanners add greatly to the diagnostic information obtained. Five illustrative cases were presented.

Figure 9—A faint nodular density is seen in the periphery of the left upper lobe (LUL).

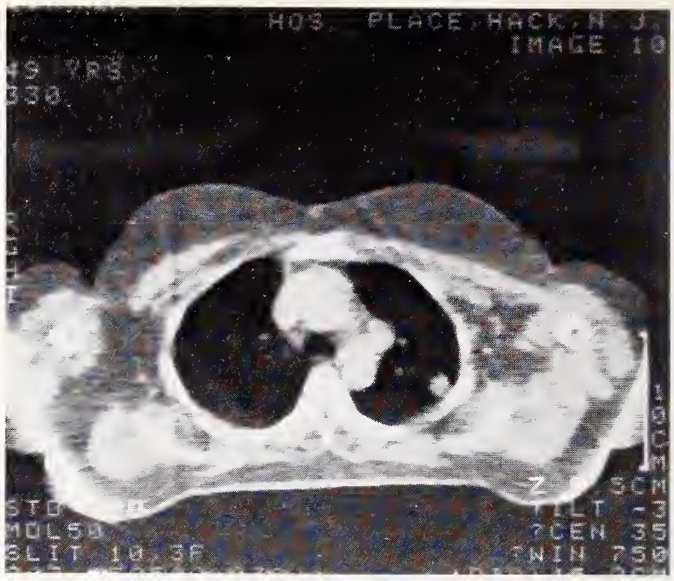


Figure 10—The nodule is seen posterolaterally with a mass in the mediastinum adjacent to the aorta.

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Adolescent Breast Disease

MARGARET S. SKILES, M.D. and
MURRAY H. SELTZER, M.D., Livingston*

A series of 118 patients, age 20 or less, who had breast biopsies is reported. Carcinoma of the breast is extremely rare in the adolescent. It is not unreasonable to delay surgery if the mass is not overtly suspicious for carcinoma.

Breast masses are not common in the child or adolescent patient and relatively little can be found in the literature about their management since most published series emphasize the pathology of lesions found at biopsy.[1,2,3] The management of most lesions in adolescent patients usually is determined by extrapolation from the management of breast masses in the adult woman.

A retrospective study of breast biopsies in patients age 20 or less was conducted to determine the frequency with which malignancies are encountered and to develop reasonable principles of management for the young patient with a breast mass.

MATERIALS AND METHODS

Records of all breast operations performed at the St. Barnabas Medical Center between 1968 and 1977 were reviewed with attention to patients age 20 and under. The pathology of the lesions was evaluated for the presence or absence of malignancy, however, due to a lack of consistency in actual pathologic diagnoses and an inability to review all the slides, detailed analysis of all the benign pathologic diagnoses was felt not to be of value.

RESULTS

There were 118 patients who underwent a total of 124 biopsies. Six patients had bilateral breast biopsies. The age distribution of all patients studied is shown in Table 1.

The indication for 117 of the biopsies was the presence of an asymptomatic mass or cyst. Other indications were a painful mass (1), a cyst which changed color (1), an abscess (1), a persistent and enlarging mass following incision and drainage of an abscess (1), and an asymptomatic increase in size of one breast without a discrete mass (3).

There were no malignancies found in any of these patients and there was no postoperative morbidity or mortality.

DISCUSSION

It is the possibility of breast cancer which makes accurate evaluation of a breast mass important. The incidence of benign breast disease far exceeds that of malignant, yet the fear of malignancy is uppermost in the mind of a woman who discovers a breast mass. Recently, both the awareness and fear of breast cancer have been increased by many articles published in the lay press. Many women now assume that the discovery of a lump in their breast means they have breast cancer. Obviously, the emotional impact and fear engendered by such a discovery is considerable in most patients, but especially in the adolescent who may be less able to cope

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Table 1
Age of Patients Biopsied

Age in Years	No. of Patients
0 – 9	0
10	1
11	0
12	2
13	1
14	3
15	5
16	7
17	15
18	30
19	30
20	24

with such emotions and stress. These fears, though unfounded, must be considered in the successful management of the patient with a breast mass.

In the adult woman, the principles of evaluation and management of dominant breast masses are well established. Successful aspiration virtually rules out the possibility of malignancy. Recurrence after aspiration or unsuccessful aspiration usually indicates the need for excision of the mass. These principles of management could be applied to the pediatric or adolescent patient, however, in these age groups, several other factors are present which should be considered and which may lead to an alteration in the above plan.

Most important is the rarity of breast carcinoma in these patients. Table 2 summarizes several series of breast biopsies performed in patients in the pediatric and adolescent age groups. Of a total of 635 patients (including the 118 in our series) two carcinomas were found, an incidence of 0.3 percent. This is far less than the incidence of positive biopsies in an adult population. In 1977, Ashikari and his colleagues at Memorial Hospital published a comprehensive listing of all the patients of pediatric cancer reported from 1888 to present. [4] This series comprised seventy-four patients. Some of these patients exhibited a variant form of juvenile carcinoma, which is secretory in nature and which seems to have a more favorable prognosis. This was first reported by McDivett and Stewart.[5] Several patients with this variant were alive and well many years after being treated solely by wide excisional biopsy. The conclusion that carcinoma of the breast is quite rare in the pediatric age group is inescapable. The probability of carcinoma with persistent breast mass in this age group is extremely low.

Usual diagnostic modalities available for older patients may not be applicable in young patients. Mammography, for example, is almost useless in the younger patient since the density of normal youthful breast tissue is such that the detail necessary for diagnosis is usually obscured. Radiation exposure is a concern in this age bracket as well.

The location of the breast mass is important in the evaluation of the pediatric patient. Symmetrical subareolar masses, particularly in preadolescence, are almost always a normal finding representing adolescent breast buds. Biopsy or excision of even a portion of this normal tissue is contraindicated since it will result in considerable deformity when the breast is fully mature.

As in the adult, a successful needle aspiration of the mass without recurrence virtually rules out the possiblity of carcinoma. This procedure is recommended.

In the pediatric patient, the choice may not be between observation and a relatively minor procedure with few risks, but between observation and a relatively major procedure comprising hospitalization, general anesthetic, time away from school and considerable psychic and emotional trauma. As discussed above, the risk of observation (i.e., the possiblity of carcinoma) is very small unless one or more clinical signs of malignancy is present.

If it is decided that a biopsy is necessary in a pediatric patient, whether for a definitive diagnosis of a clinically suspicious lesion, or to allay patient and parental fears, the risk of carcinoma is so low in these patients that other factors become relatively more important. Convenience is an important consideration; it is not unreasonable to delay excision of a breast mass until a vacation or other suitable time is available even if this represents a delay of many months. The emotional status of the patient and her ability to cope with surgery should be considered seriously. In patients who are relatively poor surgical risks for medical or other reasons, observation may be a much more viable alternative since the physician treating these younger patients need not feel the urgency to biopsy that would be appropriate in an older patient.

If observation is elected and no changes occur which make biopsy desirable, the patient eventually will pass out of the adolescent age group. When the patient is no longer an adolescent, a persistent breast mass cannot be ignored and the decision to biopsy must be made. As the patient matures a general anesthetic may not be required and a lesser procedure may be used to obtain a definitive diagnosis. In a patient who tends to develop multiple, clinically benign masses, it may be desirable to wait until she reaches a preselected age. At this time, removal of all of the masses can be performed with one anesthetic. With the patient then free of masses, routine followup can be instituted. Obviously any patient who has undergone biopsy for a mass should be taught breast self-examination and should have routine followup examinations by her physician.

It is extremely important in these young patients to minimize the resultant deformity and scarring by utilizing optimal surgical technique. A circumareolar incision should be utilized if at all possible since this becomes almost unnoticeable after healing. Attention to cosmesis is of pro-

Table 2

Author	Age of Patients	Number of Female Patients	Percent Benign	Malignancy
Turbey et al. 1975	0 – 18	42	100	0
Daniel & Mathews, 1968	12 – 21	95	100	0
Farraw & Ashikari, 1969	10 – 20	237	98.7	1 adenocarcinama (age 17½) 2 metastatic sarcama
Stane et al. 1977	0 – 21	143	99.3	1 adenacarcinama (age 20)
Skiles & Seltzer	0 – 21	118	100	0
		635		4

". . . delaying surgery for young patients with a breast mass is not unreasonable if the mass is not overtly suspicious for carcinoma."

phylactic value because a patient with an ugly disfiguring scar will be less likely to seek medical aid in the future should another mass appear. A cosmetically satisfactory incision will encourage a patient to seek help with future abnormalities.

In conclusion, carcinoma of the breast is extremely rare in the adolescent. For this reason temporizing and delaying surgery for young patients with a breast mass is not unreasonable if the mass is not overtly suspicious for carcinoma. The timing of elected excision of a mass or masses can be related to the patient's emotional state, level of maturity and socioeducational factors. In such a climate of planning, anxieties associated with biopsy can be minimized for the young patient.

SUMMARY

A series of 118 patients, age 20 or less, who had breast biopsies is reported. No malignancies were found. The authors recommend decreasing anxieties associated with a breast mass by delaying surgery until the patient is considered emotionally and socioeducationally ready, in the absence of clinical signs of malignancy.

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REVIEW ARTICLE

Food Allergy

THOMAS M. GOLBERT, M.D., Denver*

Food intolerance is diagnosed by history, diet diaries, and elimination diets. Nonallergic mechanisms must be distinguished. Food allergy is not common. Skin tests with the causative food are usually positive in immediate allergic reactions but do not confirm a diagnosis of food allergy. The only effective treatment is avoidance.

Food intolerance is an adverse reaction to specific foods which can result from a variety of mechanisms. Food allergy or food hypersensitivity is immunologically mediated intolerances to specific foods. Nonimmunologic mechanisms include toxins,[1-3] enzyme deficiencies,[4-5] pharmacologic and irritative properties of the food,[1] structural abnormalities, metabolic diseases,[1] microbial and chemical contamination,[6] and behavioral or psychological disorders.[1,3-6] Additionally, fat inhibits competency of the lower esophageal sphincter in normal individuals.[7]

Food allergy is not common.[8] Manifestations generally occur within two hours after ingestion.[9] Urticaria and angioedema occur most often.[10] Nausea, emesis, abdominal cramping, diarrhea[9], and pruritus and edema of the lips and buccal mucosa[1] occur less frequently. Other gastrointestinal manifestations are rare or unusual but include hematochezia, occult fecal blood loss,[11] malabsorption,[11] protein losing enteropathy,[12] hepatosplenomegaly,[13] eosinophilic gastroenteritis,[12] anorexia, colitis, and functional intestinal obstruction.[13] Other rare manifestations are rhinitis, asthma,[14] "bakers' asthma," anaphylaxis,[15] and the syndrome of chronic pulmonary disease, failure to thrive, diarrhea, emesis, and antibodies against milk proteins.[16] Some cases of sudden infant death syndrome,[13] eczema,[17] and possibly dermatitis herpetiformis[18] may have an apparent association with food allergy.

Food allergy has been ascribed to some cases of other syndromes, including infantile cortical hyperostosis, geographic tongue,[19] idiopathic cyclic edema,[20] Henoch-Schönlein purpura,[21] Meniere's disease,[22] migraine,[23] and various urinary tract symptoms.[24-25] Manifestations involving all tissues of the body have been claimed.[26] Headache, fatigue, malaise, irritability, and mental and emotional symptoms are a partial list. In the author's opinion, the evidence for attributing these symptom complexes to food allergy is testimonial; and a causal association is doubtful.[27]

IMMUNOLOGIC CONSIDERATIONS

A variety of immunologic responses to food antigens may be identified. At present, only the reaginic (Type I, anaphylactic) mechanism has been demonstrated conclusively with clinical manifestations of food allergy.[28] Reaginic antibodies are usually of immunoglobulin class IgE,[29] but antibodies from other immunoglobulin classes may possess reaginic activity in some patients.[30-34] The frequency with which non-IgE reagins may be clinically important is not known. These antibodies against food antigens can be detected by direct cutaneous wheal and erythema reactions and

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"A careful history is the single most important procedure in the diagnosis of food allergy."

"Elimination diets may be used when symptoms occur daily or almost daily."

by passive transfer to skin of subhuman primate and human recipients.[15] Peripheral blood basophils from patients having anaphylactic allergy to foods may release measurable amounts of histamine when incubated *in vitro* with specific antigen.[15,35] One communication has reported spontaneous release of histamine from peripheral blood leukocytes without addition of antigen as a characteristic of patients with clinical evidence for food hypersensitivity.[36] Circulating IgE antibodies can be detected by radioimmunoassay,[37] enzyme-linked immunoassay (ELISA),[38] and, less reliably, rat mast cell degranulation.[37] Release of histamine from peripheral blood leukocytes, the radioallergosorbent test (RAST), the ELISA, and the rat mast cell degranulation test presently are useful primarily, if not exclusively, for experimental investigation. Detection of reaginic antibodies against food antigens does not always correlate with the clinical situation and does not by itself establish nor confirm a diagnosis of food allergy.

Other immunologic responses to food antigens can be detected. Serum antibodies have been demonstrated by ammonium sulfate coprecipitation,[40] precipitation,[41] hemagglutination,[41] complement fixation,[42] guinea pig passive cutaneous anaphylaxis,[43] radioimmunodiffusion,[44] and enzyme-linked immunosorbent assay.[38] Utilization of serum complement[45] and detection of complement in gastrointestinal tissues[46] during gastrointestinal manifestations of intolerance to milk have been reported.[45,46] Precipitating and hemagglutinating antibodies have been observed in feces.[47] The pathogenic significance of these responses is not known. Serum antibodies of immunoglobulin classes IgA and IgG[38-48] and gastrointestinal antibodies of classes IgA, IgG, IgM, IgD, and IgE against specific food antigens have been detected in patients having nonallergic diseases and in normal subjects.[48] Observation of these changes does not have apparent diagnostic value in food allergy.[49]

Oral administration of Rhus extracts in attempts at hyposensitization is attended by pruritus ani, dyshydrosis, inflammatory stomatitis, pruritus, exacerbations in healed sites, urticaria, erythema multiforme, erythematous rashes, and erythematomacular or erythematopapular "toxic" rashes, often resembling drug eruptions.[50] However, cell-mediated (Type IV) hypersensitivity to edible substances has not been reported.[6]

Detection of an immunologic response to food antigens does not establish nor confirm clinically significant food allergy. Normal subjects have antibodies against foods. Antibodies against food theoretically could induce the pathogenesis of disease by a reaginic mechanism,[29] by complement-mediated reactions, by deposition of antigen-antibody complexes with participation of complement,[51] and by combinations of these mechanisms. Absorption of food antigens occurs in certain nonimmunological diseases and in normal subjects.[52] In these circumstances, antibodies could perpetuate tissue injury, could have no pathogenic function, or could furnish protection by rapidly eliminating these proteins from the circulation.[49] Antibodies in gastrointestinal fluids may impair absorption of food antigens.[53]

DIAGNOSIS

Methods of determining a diagnosis of food allergy are a comprehensive dietary history, diet diary, elimination diets, and cutaneous testing.

A careful history is the single most important procedure in the diagnosis of food allergy. Exacerbations of symptoms consistently associated with ingestion of a specific food are characteristic of food intolerance. An allergic or other mechanism for induction of symptoms then must be determined. This history most readily is obtained when significant symptoms follow ingestion immediately, particularly when the food is not eaten often. Patients who recognize this association often avoid the offending food without seeking medical advice.

Diet diaries and elimination diets are useful when the history is not readily apparent. The diet diary can augment the history when symptoms occur occasionally. All drugs, foods, and beverages consumed during the 48 hours before each exacerbation are recorded chronologically. Appearance of the same or related antigens consistently with symptoms suggests a causal association. This association often is not discernible. Important physical factors, contact with animals, or insect stings or bites occasionally can be observed. Cutaneous testing may be conducted with antigens appearing on the diet or antigen diary.

Elimination diets may be used when symptoms occur daily or almost daily. Lamb, rice, pineapple, and other foods which are eaten infrequently are used.[28] Foods containing salicylates and tartrazine (F D and C Yellow Number 5) ideally should be excluded.[54] Synthetic milks may be used in the rare situation requiring a total elimination diet. These milks are amino acids from the enzymatic digestion of casein.[55] An elimination diet is used for seven to 14 days. Synthetic milk diets may be used for three to seven days. Food allergy is not likely, and a general diet may be resumed if marked improvement does not occur. Rarely, abrupt exacerbation may accompany resumption of a general diet. Foods eaten within 48 hours before the recurrence may be eliminated for another seven days. Foods eaten more than 48 hours before the exacerbation may be continued. A diet diary is essential in this procedure.

If improvement accompanies the elimination diet, individual foods may be resumed at two-day intervals. Each new food is ingested by itself at breakfast the first day. Any foods already in the diet may be eaten during the remainder of the two days. The last food introduced to the diet is eliminated if symptoms recur, and no new food is added until remission is established. The exacerbation may have been coincidental

if symptoms persist for seven days. Three or more consecutive exacerbations have been recommended before excluding an important food for a prolonged period.[56] Some recommend introducing new or suspected foods in a double-blind manner.[6]

In evaluating systemic allergic reactions, a presumptive diagnosis should be accepted. Presumption may be based on historical certainty that all other temporally related antigens have been administered parenterally or orally without adverse effect after the reaction. Cutaneous tests can furnish additional information if more than one important food has not been ingested subsequent to the reaction. Skin testing can be performed much more safely than ingestion, and the causative food almost always will produce a positive reaction.[15] *If temporally related foods must be introduced, extreme caution under direct, experienced medical supervision is mandatory.*

Improvement during an elimination diet is consistent with food intolerance but does not establish a definitive diagnosis. Other treatment often is started at the same time. Many conditions, for example, eczema, have spontaneous remissions and exacerbations. Improvement can be due to the diet, to the other treatments, or may be coincidental to both.

Cutaneous tests with appropriate concentrations of antigen demonstrate the presence of reaginic antibody if positive.[35] Negative tests may not exclude food allergy, but in one investigation double-blind feeding of the suspected food did not confirm a history of immediate food allergy in any patient in whom the skin test was negative by puncture technique.[35] The food in question and the allergic manifestations may influence the reliability of cutaneous tests. Peanuts, nuts, egg, soy, milk,[6] fish, and shellfish[57] may correlate most reliably. Cutaneous tests are usually positive with immediate reactions[35] but may be negative with reactions of late onset.[58]

Foods which produce positive cutaneous tests may be eliminated for a diagnostic trial when the history suggests possible food allergy but is not clear for specific foods. Foods must not be eliminated indefinitely on the sole basis of positive cutaneous tests.[10] Many persons have positive skin tests but can ingest the foods with impunity without adverse effect. Negative cutaneous tests with reliable extracts imply that the suspected food or foods may be ingested without significant risk of a systemic or other immediate reaction.[15,36]

Testing can be executed by puncture (prick) or scratch technique on the back or forearm. Use of the forearm facilitates placing a tourniquet proximal to the test sites if a systemic reaction occurs. This precaution is necessary when evaluating the cause of anaphylaxis. *Evaluation of the cause of anaphylaxis associated with foods must be conducted with extreme caution by a physician experienced in this field.* Cutaneous testing should not be done when the cause is historically obvious. The intradermal method should be reserved for antigens which produced negative puncture tests. Many allergists do not test foods intradermally because of the risk of systemic reactions and the frequency of positive tests which do not correlate with clinical allergy.[57] Substances which are particularly dangerous and should not be applied intradermally include walnut, pecan, cabbage, broccoli, mustard, onion, asparagus, cauliflower, coconut, glue, ginger, flaxseed, caster seed, cottonseed, chlorogenic acid, buckwheat, perch, salmon, smelt, whitefish, clam, oyster, lobster, and shrimp.

A variety of tests are useful investigational methods. These techniques include the radioallergosorbent test (RAST),[39] the enzyme-linked immunosorbent assay (ELISA),[38] passive transfer (Prausnitz-Küstner, P-K) to skin of subhuman primate or human recipients, release of histamine from peripheral blood basophils[15,35] and from chopped human lung,[59] the rat mast cell degranulation test,[37] and the skin window eosinophilia test.[60]

"Avoidance is the only effective specific treatment of food allergy."

The RAST[39] and the ELISA[38] may become useful adjuncts in the investigations of anaphylaxis associated with ingestion of more than one food and in the initial evaluation of selected cases of eczema[61] in which extensive lesions would interfere with direct skin testing. More experience is necessary to ascertain the clinical value of the ELISA. The RAST has become subject to various abuses and, in the author's opinion, has limited clinical usefulness in situations which require a search for reaginic mechanisms.[62] It is less sensitive than the puncture test and comparable to the human passive transfer test.[63] Modest amounts of IgG antibodies may mask the presence of IgE antibody in RAST systems.[62] The RAST will not identify reagins of immunoglobulin classes other than IgE. The RAST has not been validated thoroughly in the evaluation of anaphylactic states, and the additional sensitivity furnished by skin testing may be clinically important.[62] In the evaluation of eczema, a higher incidence of positive RAST than puncture tests has been reported.[64] The incidence of positive RAST which did not correlate clinically was also higher than the puncture tests among these patients.[64]

Other investigational techniques for discerning reaginic antibodies are not useful clinically. Passive transfer tests are relatively insensitive with monkey recipients and should not be used with human recipients because of the risk of transmitting viral hepatitis and other communicable diseases. Release of histamine from peripheral blood basophils[15,35] does not establish nor eliminate a diagnosis of food allergy. Release of histamine from chopped human lung is relatively insensitive and not available clinically.[59,63] The rat mast cell degranulation test is technically difficult and not reliable.[37]

The skin window eosinophilia test requires a glass slide applied to abraded skin for 24 hours. This procedure has been reported to induce positive reactions with essentially the same food antigens in the same patients as the scratch test.[60] One communication interpreted some skin-window tests as positive although they contained a smaller percentage of eosinophils than were observed in the peripheral blood.[60]

Other procedures have been espoused for the diagnosis of food allergy. In the author's opinion, the basophil degranulation test,[65] the leukopenic index, the pulse test, the leukocytoxic test, and sublingual and intracutaneous provocative tests with the so-called provoking dose and neutralizing dose have not been proved valid and should not be used.[27]

Avoidance is the only effective specific treatment of food allergy.[49] Although most foods are avoided easily, some may be eaten inadvertently in concealed form. For example, nuts

frequently are used in candies, cookies, and pastries. Wheat, milk, and eggs are common ingredients in prepared foods. Examination of the ingredients of commercially prepared foods may not preclude inadvertent ingestion. As an example, various combinations of wheat, barley, oat, rye, corn, cottonseed, and flaxseed may be included in the term, "flour." Accidental ingestion also may result from immunological cross-reactivity among biologically related foods.

Special processing of foods sometimes denatures the antigen, thus allowing use of the food. However, no method reliably achieves avoidance of the antigen. Common methods of processing include dehydration, cooking, and spray drying. Symptoms may follow ingestion if one or more of the allergens is stable under the conditions of processing.

Milk substitutes or specially processed milks may be suitable for the infant with milk allergy. These include synthetic milks, meat milks, poi, soybean milks, modified milks, evaporated milk, boiled milk and dried milk, in approximate order of decreasing price. Generally the less expensive preparations may be attempted first, but with immediate systemic reactions, all milk preparations should be avoided. Feeding breast milk or soy formulas instead of cow's milk, with or without the omission of egg yolk, during the first six months of life has not been confirmed to prevent the development of childhood allergy.[66] Breast feeding during this period has been reported to be associated with an increased incidence of IgE antibodies against cow's milk.[67]

Complications of avoidance may include growth retardation, vitamin deficiency disorders, and impairment of musculature. These sequelae of extended nutritional deprivation are preventable.[1] Psychological dependence on an unsound diet also can result from an erroneous diagnosis of food allergy.

Multiple food allergies in individuals are common but include relatively few foods. A balanced diet rarely, if ever, is precluded. Nutritional deficiency should not complicate even the most restrictive elimination diet because seven to fourteen-days trial is sufficient. If systematic introduction of foods is elected, resumption of a balanced diet can be achieved within two to three weeks. Malnutrition is not a justifiable complication of dietary management of food allergy.[19]

Spontaneous remission of food sensitivities occur frequently, with or without abstinence. This event may result from maturation of the digestive system, of the immune system, or of both with consequent impediment of absorption of undigested antigens.[49,52,53] Cautious reevaluation of nutritionally important foods may be conducted at three to six-month intervals.[10] However, with immediate reactions, especially having hypotensive or respiratory manifestations, permanent abstinence is advised. Sensitivity to fish or nuts rarely disappears.[1]

With the possible exception of "bakers' asthma," hyposensitization by any route has not been proved beneficial and is not indicated.[1,10,49,55]

Symptomatic management of food allergy is the same as treatment for the specific problem resulting from other causes. For example, adrenergic drugs, antihistamines, and sometimes adrenocorticosteroids are useful. Additionally, cromolyn[68,69] and anticholinergic agents may be beneficial in treating gastrointestinal manifestations, such as diarrhea[68] and possibly asthma and angioedema.[69]

SUMMARY

Food allergy is an uncommon adverse reaction to a specific food by an immunologic mechanism. It must be distinguished from other causes of food intolerance. Diagnosis of food intolerance is established by history, diet diaries, and elimination diets. Only the reaginic (anaphylactic; Type I) mechanism has been associated conclusively with food allergy. Skin tests with the causative food are positive in most patients having immediate allergic reactions. They do not establish nor confirm a conclusive diagnosis of food allergy. The only specific treatment is avoidance.

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Wernicke's Encephalopathy in the Nonalcoholic

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Wernicke's encephalopathy was recognized in two patients receiving intravenous therapy for gastrointestinal disorders. The diagnosis was delayed in both cases because alcoholism was not involved. An expanded index of suspicion may serve to expose or avert the disease in other patients with similar ailments.

Wernicke's disease is described by a constellation of findings none of which alone is very suggestive of the diagnosis. Confusion, ocular palsy, nystagmus, peripheral neuropathy and ataxia are all common neurologic problems with many possible etiologies among which thiamine deficiency is not one of the more frequent unless the setting is one of acute alcoholism. It is in other situations that the index of suspicion necessary to equate some combination of the above findings with the correct diagnosis may be lacking.

The following cases describe two patients who were treated with intravenous fluid for illness unrelated to alcohol abuse and who were recognized as having Wernicke's encephalopathy. They were successfully treated.

CASE REPORTS

Case 1—A 72-year-old male was admitted to the gastroenterology service because of pyloric outlet obstruction. He had been treated for peptic ulcer disease 15 years ago but had had no problems until six weeks prior to admission when he was hospitalized in Florida because of anorexia and vomiting. During that hospitalization he complained of weakness of the left foot with marked foot drop. He was told the weakness was due to low potassium and he was treated for it. With time he became able to eat and his foot gradually recovered its strength.

Three weeks prior to admission he again developed anorexia and vomiting. He admitted to a 40-pound weight loss since the start of the illness. Endoscopy revealed pyloric outlet obstruction by probable tumor. The patient was admitted to the hospital and maintained on intravenous fluids consisting of dextrose and electrolytes while plans for operation were made.

Neurologic consultation was requested when the patient noted increasing weakness of the left foot which had begun to recur two weeks prior to hospitalization. The right foot began to feel weak as well. He was totally unable, he said, to bend either ankle upward. On further questioning he revealed that he and other family members had always had rather high-arched feet but that none of them had suffered any weakness from it.

Physical examination revealed a thin, alert, elderly male in bed with nasogastric and intravenous tubing in place. Vital signs were normal. Cranial nerve examination revealed equal reaction of the pupils and normal fundi. There was horizontal nystagmus on right and left lateral gaze. He had diplopia on the left lateral gaze due to a partial left sixth nerve paresis. There were similar though less severe findings on the right. Upward gaze also was limited. The remainder of the cranial

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nerves were normal. There were no carotid bruits. The heart and lungs were normal and the abdomen was soft.

There was normal strength in the upper extremities. Proximal muscle strength was normal in the lower extremities but distally there was decreased flexion; inversion was normal. The feet had strikingly high arches bilaterally with marked atrophy of the muscles of the left anterior tibial compartment. The deep tendon reflexes were absent at the ankles but were normal elsewhere. There was decreased pinprick sensation and decreased proprioception and vibratory sense in both feet. Cerebellar testing was normal in the upper extremities, but there was heel to shin ataxia. When assisted to stand, he felt dizzy and could not walk. There was no drop in blood pressure upon standing.

Laboratory abnormalities on admission included a potassium of 2.4 mg/dl, a chloride of 78 mg/dl, and a calcium of 7.9 mg/dl. Serum albumin was 3.0 mg/dl.

A diagnosis of Wernicke's encephalopathy, superimposed on mild Charcot-Marie-Tooth disease to account for the prominent peroneal nerve palsy, was suspected. This was suggested strongly by the family history of high arched feet. An intravenous bolus of 100 mg of thiamine chloride was administered. By the following day the patient's extraocular movements had recovered almost completely. There remained mild nystagmus and diplopia only on extreme left lateral gaze. There was definite, though less dramatic, recovery of dorsiflexion strength which continued to improve daily. The ataxia lessened daily as well. Thiamine was continued in a dose of 50 mg. by intramuscular injection twice daily.

Operation revealed gastric carcinoma which was resected. When allowed to eat, the patient was switched from parenteral to oral vitamin replacement. After fourteen days he was eating well and fully ambulatory without footdrop, visual disturbance or ataxia. Plans were made for radiotherapy treatments and vitamin therapy was continued orally at the time of discharge.

Case 2—A 62-year-old male was admitted to the hospital because of vertigo, nausea and vomiting. He had complained of intermittent vertigo and unsteadiness of gait for several weeks but the nausea and vomiting was of acute onset. There also were complaints of periodic double vision.

The past history included a hemigastrectomy and partial small bowel resection for peptic ulcer disease in 1948. He had recently had a prostatectomy and orchiectomy with ileal conduit resection for malignancy which was believed to be confined to the gland.

At the time of admission he was taking aspirin and persantin as well as a daily multivitamin tablet. He stated that these medications did not seem to be helping.

The patient was a thin, elderly male in bed with an intravenous infusion in his arm. He stated that he always had been thin since the hemigastrectomy and that he had not lost any weight recently nor had he changed his eating habits. He was fully alert, cooperative and afebrile. Blood pressure was 110/70 supine and sitting.

The pupils were equal and reactive and the fundi were normal. There was limited abduction of the left eye with diplopia on left lateral and on upward gaze. There was no facial assymetry; hearing was normal. The neck was supple, the thyroid normal and there were no carotid bruits. The chest and abdomen were normal.

The extremities were thin but muscle strength was normal. Reflex and sensory testing was physiologic. The gait testing revealed truncal ataxia and dysmetria of the left leg. The left leg was also dysmetric on heel to shin testing. The Rhomberg test was positive.

"The need for the parenteral administration of thiamine to hospitalized patients suffering from acute alcoholism or related illness is well recognized."

There were no striking laboratory abnormalities. The CBC revealed a mild anemia-Hgb 12.6, Hct 36.8; MCV 92; MCHC 34.3; MCH 31.7; WBC 5.6 (N51, B 0, L 47, M 2 E O); ESR 30; Serum B_{12} 644 (300-1000); serum folic acid 3.5 (4-16); $T_4$5.8. There were no abnormalities on the chemical profile.

Neurologic consultation was obtained. The initial differential diagnosis included: (1) a posterior fossa lesion (2) vertebrobasilar artery insufficiency, and (3) viral gastroenteritis with vestibular neuronitis. A CT brain scan was negative.

The patient failed to improve. A diagnosis of Wernicke's encephalopathy was considered by the neurologist and intravenous thiamine was administered followed by intramuscular injections of 50 mg. twice a day. In three days all neurologic abnormalities cleared. There was full range of extraocular motion, no nystagmus and no diplopia. There was no ataxia of gait and the Rhomberg had become negative. He was discharged on daily multivitamin tablets, weekly injections of thiamine and hematinic vitamins and thiamine chloride 50 mg orally twice daily.

Four months later, while still receiving all vitamins as indicated above he again began to develop episodic spells of vertigo and diplopia. He failed to improve when the dosage of thiamine was increased to 100 mg orally twice a day. He was hospitalized for restudy. A parenteral dose of 100 mg B_1 was again found to produce rapid clearing of the neurologic syndrome. By afternoon after a 9 am injection he felt fine. The following day, however, brought the return of mild symptoms and by the third day he required another injection. He could not be maintained on less than three injections per week. He was instructed in self-medication and subsequently was discharged.

DISCUSSION

The need for the parenteral administration of thiamine to hospitalized patients suffering from acute alcoholism or related illness is well recognized. Wernicke's encephalopathy was found to represent three percent of all alcoholic neurologic disorders at Boston City Hospital.[1] One should recall, however, that the nutritional etiology of the disorder when first established in the late 1930s was studied not in alcoholism but in such disorders as hyperemesis gravidarum, intestinal obstruction with vomiting and in chronic gastritis. It is remarkable then that a prominent modern textbook of medicine should cite only such rare instances as prisoner-of-war camps and generalized wasting diseases as alternatives to alcoholism to be included in the differential diagnosis of the disease.[2]

The neurologic deficit in the first patient was initally attributed to severe hypokalemia. His subjective complaints

were limited to the foot-drop making the diagnosis of an encephalopathy remote. It easily might have been missed without complete neurologic examination which disclosed the classical eye findings and the sensation of dizziness and ataxia without orthostatic hypotension when the patient was assisted to stand.

Thiamine deficiency can be suspected even without these typical findings when the setting is suggestive.[4] A thiamine deficiency syndrome given the name alcoholic beriberi is described with findings limited to bilateral foot and wrist-drop with disturbed sensation over the outer aspects of the legs.[3] Slight variations in the severity of the vitamin deficiency as well as variations in duration can cause differing presentations. Mild deficiency over prolonged periods of time tend to produce the peripheral neuropathy and later beriberi, while acute severe thiamine deficiency favors the encephalopathic presentation.[3]

It was appropriate that our patient displayed findings consistent with either presentation because he had both mild chronic thiamine deficiency due to the pyloric outlet obstruction as well as severe acute deficiency caused by the intravenous infusion of dextrose without vitamin supplementation. A further variation in presentation was derived from his mild Charcot-Marie-Tooth disease which predisposed him to foot-drop with sparing of the wrists.

In the second case, as in the first, the diagnosis of nutritional encephalopathy was not considered in the initial differential diagnosis. The patient had had a hemigastrectomy thirty years earlier and only recently had become ill. The fact that he already was taking vitamins at the time of presentation further may have lowered the index of suspicion. Once considered, the diagnosis of Wernicke's encephalopathy was accountable for all of the findings.

The rapid response to intravenous thiamine was typical,[1] but resistance to oral thiamine also has been reported.[5] The vitamin has been shown to be absorbed actively in normal humans in the duodenum and proximal jejunum. In malnourished and alcoholic patients a two-thirds reduction in absorbtive capacity has been demonstrated. It is postulated that this is due to a decreased number of receptor sites for the vitamin at the brush border. This defect ordinarily clears with improved nutrition.[5]

Our patient failed to develop adequate absorbtive capacity for thiamine even after his nutrition was properly supplemented. His proximal small bowel resection and hemigastrectomy may have reduced permanently the number of thiamine receptor sites to marginal levels, while the recent bowel resection to form the ileal conduit for bladder bypass decreased their number even further, if not eliminating them altogether.

As noted in the case presentation, he relapsed approximately four months after the hospitalization during which he received intensive parenteral vitamin replacement. In the total absence of thiamine, the deficiency syndrome has been produced in 14 days.[3] The weekly injection and oral vitamins were apparently adequate only to delay the reappearance of the syndrome. He relapsed within three days of an injection. The storage capacity for thiamine in humans with normal muscle mass is 30 mg.[6] Our patient was rather thin, but whether this alone is accountable for such short remissions is unknown.

When told that he would have to inject himself with the vitamin on a regular basis at home he made the apt analogy to insulin dependence. A precautionary analogy should also be made to the point that anaphylaxis has been reported.[8] Unlike insulin, which can be injected subcutaneously, thiamine must be given intramuscularly.[9]

Of the several clinical findings that may be present in Wernicke's encephalopathy the acute mental syndrome—often referred to as the global confusional state—is one of the more commonly present. Both our patients were quite lucid at all times. A large series reported that ten percent of their cases were similarly free of mental abnormalities but no explanation was offered.[1] The diagnosis of encephalopathy is nevertheless appropriate because the ophthalmic and ataxic disorders have correlates in brain pathology if allowed to persist long enough.[4]

In both patients the diagnosis of Wernicke's encephalopathy was confirmed by the rapid response to intravenous thiamine. Vitamin assays and measurement of erythrocyte transketolate enzyme activity are available to measure thiamine deficiency in the laboratory but in the proper setting, a good clinical response is adequate to make the diagnosis.[7]

CONCLUSION

Two cases of Wernicke's encephalopathy in nonalcoholic patients were presented. Each patient was suffering from a gastrointestinal disorder capable of causing malnutrition. In each case the illness flared and was subsequently recognized after treatment with intravenous dextrose solutions without vitamin supplement. In each case symptoms were present even before intravenous therapy was instituted. Symptomatic thiamine deficiency can occur in the United States in the absence of alcohol and intravenous alimentation. This report emphasizes that the recognition or prevention of other cases of Wernicke's encephalopathy may be facilitated if the physician places gastrointestinal disorders and operations alongside alcohol as stimuli to his index of suspicion for Wernicke's encephalopathy and the need for vitamin therapy or prophylaxis.

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Bone Marrow Metastasis From Glioblastoma Multiforme

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A case of glioblastoma multiforme which metastasized to the bone marrow is described. Distant metastasis from glioblastoma multiforme is rare. Most common sites of metastasis in order of frequency are lymph nodes, lungs, and bones. Different factors contributing to rarity of remote metastasis from these tumors are discussed.

Distant metastasis from brain tumors of neuroectodermal origin are well known, but they occur rarely. Considering that glioblastoma multiforme is one of the most malignant tumors of the brain, extracranial metastasis is very uncommon. Most examples reported in the literature have occurred after craniotomy. Only six patients have been reported who did not have craniotomy prior to occurrence of remote metastasis.[1,2,3]

CASE HISTORY

A 55-year-old female presented with headaches, dizziness, and a musical sound in her ear in December 1977. Physical examination at the time was unremarkable. Brain scan showed increased uptake in the left temporal parietal region; a chest x-ray was normal. Carotid angiogram revealed a large avascular mass involving most of the temporal lobe. Electroencephalogram (EEG) was abnormal due to the presence of lateralized left anterior cerebral slowing. Computerized tomography (CAT) confirmed the presence of a tumor mass in the left temporal region. The patient had a craniotomy and resection of the tumor. Pathologic examination revealed glioblastoma multiforme. The patient was given 6,000 rads of radio therapy and dexamethasone was prescribed.

Four months later the patient complained of pain in the lumbar region and noted petechiae and ecchymosis on her skin. Physical examination revealed a cushingoid appearance, and multiple petechiae and ecchymoses all over her body. There was no neurologic deficit. White blood count was 3.6, hemoglobin 10.1 gm/dl, hematocrit 30, and platelets 37,000. The red blood count and indices were normal. Bone scan showed irregular and mottled uptake throughout the thoracic and lumbar spine; liver scan was not diagnostic. Chest x-ray and tomogram were negative.

Bone marrow aspiration from sternum showed complete replacement of the marrow with tumor cells (figures 1, 2). Bone marrow clot confirmed tumor invasion of the marrow consistent with glioblastoma multiforme. The patient did not respond to the treatment and died two weeks later. Autopsy was performed. The liver was found to be involved with metastatic glioblastoma multiforme. Other organs were free of metastasis.

DISCUSSION

The rarity of distant metastasis of glioblastoma multiforme still is not well understood. Considering the malignant nature of these tumors, numerous explanations have been suggested:[16]

a. Absence of true lymphatic linkage between the central nervous system and the rest of the body.

b. Presence of dense dural coating of venous sinuses tends to retard invasion by neoplasm.

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Figure 1—Bone marrow with multiple clusters of tumor cells.

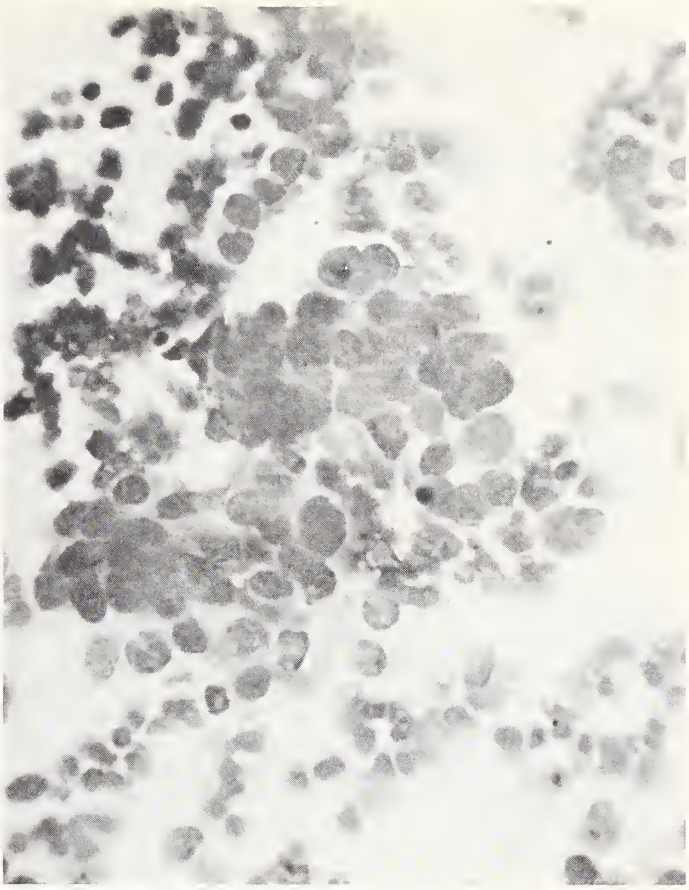

Figure 2—Bone marrow with tumor cells. (high power)

c. The walls of small cerebral veins are thin and easily may collapse in the face of the invading tumor.

d. The central nervous system (CNS) is unique: tumor tissue from CNS origin fails to grow readily in a foreign environment.

e. Rapid evolution of more malignant forms of glioma leads to early death; the short duration prevents the formation of metastatic foci.

Review of the cases reported in the literature reveals that surgical intervention by craniotomy is the most important factor contributing to the extracranial metastases of glioblastoma multiforme. Also of interest is recognition of tumor cells in the systemic circulation during surgery.

Glasaner and Yuan reviewed 89 cases, 16 of which were glioblastoma multiforme.[4] Smith reviewed 8,000 tumors of neuroectodermal origin and reported 23 cases of glioblastoma multiforme with distant metastasis.[5] Komatsu *et al.* reviewed the literature in 1972 and reported 14 additional cases.[6] Since then 15 more cases have been reported in literature;[7-13] two of them had no previous craniotomy;[2,3] one case metastasized through a ventriculopleural shunt.[14] Three cases metastasized along the spinal meninges.[15]

Lymph nodes, especially cervical lymph nodes, are the most favored location of extracranial metastasis. The three major sites of distant metastasis in order of frequency are lymph nodes, lung and bones.

The case reported in this paper showed definite evidence of hematogenous spread, which involved bone marrow and liver. One can postulate that surgery disturbed the so-called blood-brain "barrier" and allowed invasion of blood vessels by tumor cells. Furthermore, excising of a bone flap and incision of the dura for decompression gives neoplastic cells a chance to invade directly into scalp and/or muscle.

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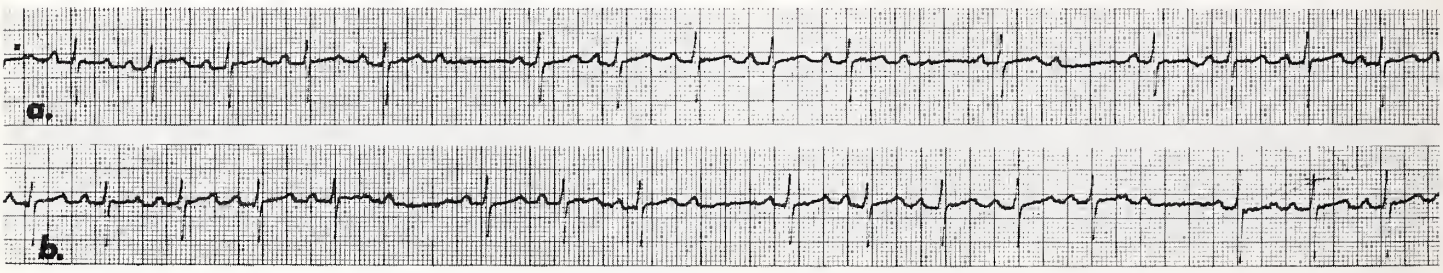
Type II (Mobitz) Atrioventricular Block with Narrow QRS Complexes

EDWIN L. ROTHFELD, M.D., Newark*



Strips A and B are a continuous recording of a monitor lead in a 79-year-old woman who was admitted to the hospital for management of progressively severe congestive heart failure owing to long-standing coronary heart disease. At the time of admission, there was clear-cut clinical and chemical evidence of digitalis toxicity. The conduction defect seen in the figure disappeared after digoxin was withheld, there was no progression to more advanced block and pacing was not required. Yet, she died six days after admission in refractory heart failure.

The tracing indicates a normal sinus rhythm with an atrial rate of 100 per minute, constant PR intervals of 200 msec., QRS complexes of normal duration and sporadically non-conducted P waves that are of sinus origin and are not premature. This constellation is a rare example of type II (Mobitz), second degree atrioventricular (A-V) block without bundle branch block.

In 1924, Mobitz described the electrocardiographic features of two forms of second degree A-V block which traditionally have been designated as type I (Wenckebach), and type II (Mobitz)[1]. Type I is characterized by a progressive lengthening of PR intervals preceding a blocked P wave, and type II has sporadically non-conducted P waves with constant PR intervals and QRS complexes of abnormal duration and contour. Electrophysiologically, type I is usually an intranodal lesion while type II is an infranodal defect generally manifested as a form of bilateral bundle branch block where the conducted impulses show bifascicular block, and the blocked P wave is due to transient, trifascicular block. That there is a need for such a distinction is especially apparent in the setting of acute myocardial infarction. Type I usually is associated with infero-posterior infarction, reversible ischemia of the A-V node and rarely requires artificial pacing. On the other hand, type II is an ominous finding related to large, anterior infarcts, irreversible necrosis of the trifascicular intraventricular conduction system; immediate pacing is mandatory to avoid sudden, electrical death [2,3]

Narula and Samet first described three cases of type II A-V block with narrow QRS complexes in whom electrophysiologic evaluation indicated that the conduction defect was in the proximal His bundle. [4] Interestingly, as in my case, all three of their patients were elderly women. Rosen and his associates published three additional cases of type II A-V block with normal QRS complexes in whom they demonstrated an intranodal lesion.[5] Two of these three patients had evidence of digitalis toxicity, the apparent etiologic agent in my patient as well. Unlike the usual form of type II A-V block due to infranodal disease, Rosen's patients had a remarkably benign course. The block was transient; none developed complete heart block and none required pacing. Yet, in a later paper, the same group described a single patient with type II A-V block and narrow QRS complexes who had definite Stokes-Adams seizures.[6] Finally, Gupta *et al.* reported two patients with type II A-V block and narrow QRS complexes, in one of whom digitalis was the likely culprit.[7] I must emphasize that while digitalis overdosage is a common cause of type I A-V block, it rarely if ever leads to ordinary type II A-V block.

The differential diagnosis of type II A-V block with narrow QRS complexes includes non-conducted atrial premature impulses, type I A-V block with minimal PR interval changes and concealed His bundle premature impulses. Non-conducted atrial premature impulses may be distinguished by the prematurity of the blocked P wave and its altered contour, duration or polarity. Type I A-V block with minimal PR change can be very difficult to identify precisely; therefore analysis of long strips may be necessary to differentiate it from type II A-V block with narrow QRS complexes.

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Non-propagated His bundle premature impulses cause a pseudo A-V block that requires His bundle electrography for accurate differential diagnosis.[8]

SUMMARY

Type II A-V block with narrow QRS complexes is an unusual conduction defect that has a predilection for elderly women. Unlike ordinary type II A-V block, this form is often related to digitalis toxicity. It has a relatively benign prognosis since complete heart block rarely supervenes and pacing has been required in only one reported case.

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Why Salt? How Much?

WILLIAM J. DARBY, M.D., New York*

SALT AND ITS HISTORY

Chemically, salt is sodium chloride (NaCl) with minor admixture of other inorganic chemicals, several of nutritive value such as iodide. Wild animals and early man hunted "licks" as sources of salt. Usefulness of salt for preservation of food and in numerous crafts further enhanced its value. The word "salary" stems from an allowance of salt in payment for services. Today the industrial use of salt far exceeds that for food—of the total of 24.5 million tons produced in 1978, only 4.1 percent was food grade for all food processing uses.

Sodium is essential in the regulation of body water, maintenance of osmotic pressure of body fluids, the permeability of cell membranes and control of acid-base equilibrium.

The physiologic requirement for sodium in healthy people varies with age, environmental temperature, humidity and level of physical activity. The estimated safe and adequate levels of dietary intake for *sodium* has been set as 250 to 750 mg for infants 6 to 12 months of age, 600-1800 mg for children 7 to 10 years of age and 1100-3300 mg for adults.[1] *This is equivalent to a safe and adequate daily intake of 2.8 to 8.4 g of salt for adults.* An adult under conditions compatible with minimal losses of salt can maintain sodium balance on less than 0.5 g of salt daily.[1]

Salt readily is excreted by the normal kidney, excretion increasing with dietary intake and decreasing during salt restriction. Renal losses by the adult of 2.5 to 5.0 g of sodium daily (equivalent to about 6.0 to 12.5 g of salt) are usual; cutaneous excretion varies and is determined by factors that alter sweat losses. Sweat losses of one liter/hour for eight hour periods occur in some heavy industries, and two liters/hour may occur in competitive distance runners. Conversely, continuously low-intake levels of salt may result in increased urinary aldosterone levels and conservation of body salt reflected in low urinary loss. Thus, maintenance of salt balance is normally accommodated throughout a wide range of intakes.

APPETITE FOR SALT

The appetite for and behavior toward salt intake suggest a mild aversion in early childhood but not inhibition of salt intake. Studies in children, ages one to three years, indicated rejection of salt *per se,* even though the young child's recognition thresholds are comparable to those of adults.[2]

A taste preference study[3] of children 9 to 15 years of age and adults showed that the majority preferred the mildest salt solution (0.29 percent), but some twenty percent selected the saltiest sample (2.34 percent). There were no sex differences for salty taste. In the younger group, more blacks than whites selected stronger salt solutions—thirty percent of young blacks preferring the saltiest sample. A similar trend was present among adults. These observations indicate that populations are not homogeneous in their preferences of saltiness. Whether differences in preference reflect differences in requirements or in experiences and learned preferences is not known. There is much evidence from animal studies that changes in sensitivity to preference and appetite for salt can depend on a variety of endocrinological factors.

ESTIMATES OF SALT INTAKE

Estimates of usual intakes of salt have a reliability similar to estimates of intake of other nutrients, being neither more nor less accurate. Professor E.V. McCollum and associates estimated in 1939[4] that "man consumes 3 to 6 g of sodium in the ordinary daily diet, the greater part of which is supplied by the sodium chloride added as seasoning." This is equivalent to approximately 8 to 15 g of NaCl daily. Estimates by the Salt Institute place current average intake at 8 to 10 g daily;[2] excretion studies indicate it at some 10 g daily.

The Select Committee on GRAS Substances (SCOGS) of the Life Sciences Research Offices of the Federation of American Societies for Experimental Biology reviewed available information on amount and sources of salt in the American diets.[5] They considered evidence of salt usage in the food industry from a 1970 and a 1979 National Research Council Survey, the FDA "market basket" studies, available data on excretion of sodium and data on production and sales of salt. They wrote ". . . several direct and indirect estimates of discretionary (consumer controlled), nondiscretionary (naturally occurring and added in industrial processing), and total sodium chloride intakes for adults have been examined—these estimates are considered very rough approximations of the national average. The best estimate of sodium intakes by adults based on these data is an average

*Reprinted with permission of *Contemporary Nutrition* 5:6 (June) 1980, a newsletter from the Nutrition Department of General Mills, Inc., Minneapolis. Dr. Darby is President of the Nutrition Foundation, 489 Fifth Avenue, New York 10017.

daily intake, expressed as sodium chloride, of not less than 10 to 12 g. Discretionary use accounts for about one-third of this total; estimates vary from about one-fourth to one-half (3.4 to 6.5 g). The nondiscretionary intake is contributed by about 3 g of sodium chloride (sodium occurring naturally in foods expressed as sodium chloride). By difference, the average diet provides the equivalent of about 4 to 6 g of sodium chloride from sodium chloride and other sodium-containing ingredients that were added to foods during commercial processing.[5]

The SCOGS' estimate of salt intake is higher than that of other recent ones but reflects the variation in judgmental factors that enter into such approximations, rather than evidence of increased use of salt. In fact, the SCOGS' analysis supports their statement that "the total amount of sodium chloride used by the food industry is decreasing."

Current studies reveal that the salt intake of infants and young children increases about four-fold when the infant ceases to be fed commercially prepared infant foods and begins to eat the family fare as prepared for general consumption. This is becasue of the *low* content of salt in manufactured infant foods. For over a decade (since 1969) there has been a pronounced reduction in salt added during the manufacture of infant foods and none currently is added by some of the largest processors.[6,7]

ACUTE SALT DEPLETION

Symptoms of nausea, vomiting, dizziness, apathy, exhaustion, painful cramps and circulatory failure occurring among workers exposed to elevated temperatures under conditions conducive of extensive sweating long have been termed "miner's cramps." These symptoms are relieved by ingestion of sodium chloride, along with the replacement of water loss. Ingestion of sodium chloride tablets by those engaged in intense physical activity, such as athletes, is *not* currently recommended. Ingestion of water is the most important safeguard of physical status and performance in heavy athletic competition. The dietary intake of salt at mealtimes is adequate for meeting most needs, but if prolonged losses do endanger body salt balance, the salt should be supplied in drinking water as a 0.1 percent solution, not as salt tablets.

TOXICITY OF EXCESSIVE SALT

The SCOGS' Report has reviewed much of the extensive literature on the toxicity of excessive salt intake.[5] It is well established that grossly excessive levels of salt can be acutely toxic and even fatal. For example, instances have occurred in which salt, instead of sugar, was added to infant formulas. Such massive quantities proved fatal.

High levels of feeding sodium chloride (1 to 2 g/kg body weight daily) in children maintained on a low-potassium diet increased systolic and diastolic blood pressure levels, an effect that could be prevented or greatly lessened by increasing the potassium intake.

DIETARY SALT AND HYPERTENSION

Efforts to correlate salt intake with incidence of hypertension in homogeneous populations have not provided definitive evidence of a causal relationship. Despite the fact that marked restriction of sodium intake to levels of 200 to 500 mg often reduces blood pressure, patient compliance with such drastically low-salt diets is rare. Moderate salt restriction is of value as one of a combination of measures in management of hypertensive individuals, but the intake levels should be determined and monitored by a physician.

Very recent studies by Bernard *et al.* examined the urinary sodium excretion, plasma renin activity and taste responses of hypertensive and normotensive individuals.[8] Dietary intakes were not estimated. A subgroup of the hypertensive population exhibited higher sodium excretion, lower renin activity and rated sodium chloride solutions significantly more acceptable taste-wise than did a group of normotensive controls, matched carefully for age, sex and race. They have suggested that the combination of high-salt intake, low-plasma renin activity and increased pleasantness of salt taste constitutte a form of essential hypertension in which the biological mechanisms that regulate the sodium balance of the body are reset at a higher level. Studies such as these may, in the future, clarify the nature of the defect(s) in sodium metabolism that is (are) associated with so-called essential hypertension.

CONTROVERSY ON SALT INTAKE LIMITATION

Hypertension is a sign, not a disease entity, and may result from a variety of causes through various mechanisms. Epidemiologic studies do not provide decisive evidence of causative relationship between the levels of salt intake widely consumed in the United States and hypertensive disease. Also, a severe decrease in salt intake appears to be necessary to treat the problem of hypertension.

These points are recognized even by those who vigorously advocate reduction in salt intake. For example, the recently published *Dietary Guidelines for Americans*[9] from the U.S. Department of Agriculture and the U.S. Department of Health, Education and Welfare states in part: "The major hazard of excessive sodium is for persons who have high blood pressure; not everyone is susceptible. In the United States, approximately 17 percent of adults have high blood pressure. The sodium intake is but one of the factors known to affect blood pressure. Obesity, in particular, seems to play a major role. "At present there is no good way to predict who will develp high blood pressure, though certain groups, such as blacks, have a higher incidence. Low-sodium diets might help some of these people avoid high blood pressure if they could be identified before they develop the condition."

Despite this, several publications including these *Guidelines*, the SCOGS' Report, *Healthy People* from the Surgeon General[10] and *Toward Healthful Diets* from the Food and Nutrition Board of the National Academy of Sciences[11] all recommend a moderate reduction in sodium intake regardless of the individual's habitual dietary salt intake or blood pressure.

Foodstuffs recommended for reduction by the *Guidelines* include cheese, cured meats, potato chips, salted nuts and sauces. It would be useful to look at actual sources of salt in the diet and the nutritional contribution of the foodstuff. In this regard, the SCOGS' Report indicates that food contributing most to the "possible average daily intake" of 7.1 g of salt added to processed foods were meat products (1.9g), baked goods (1.8g) and cheese (0.1g), while snack foods contributed less than 0.05 g daily.[5]

Care must be taken when making recommendations for the general public to avoid specific foods on the basis of the amount of salt or other ingredients and not to advise an undesirable reduction in intake of highly nutritious, nutrient-dense foodstuffs. It is also important to recognize the hedonic component of food acceptability can result in elimination of a particular food or a food group from the pattern of consumption.

SUMMARY

Present information concerning dietary salt intake justifies the following conclusions: (1) the estimates of "per capita intake" of salt in the U.S., while clearly above the minimal physiologic need, are within the range of physiologic accommodation by the healthy individual; (2) acute grossly excessive or low levels of salt intake can be toxic; (3) general, moderate reduction in dietary salt intake cannot predictably be anticipated to decrease the *development* of hypertension; (4) some individuals with hypertension, however, do benefit from limitation of sodium intake at levels appropriate to the therapeutic regimen advised by their physician; and (5) the role of the diet in the cause or prevention of hypertension has not yet been defined.

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Selected Abstracts with Comments

Yamanouchi I, et al: Transcutaneous bilirubinometry: Preliminary studies of noninvasive transcutaneous bilirubin meter in the Okayama National Hospital. *Pediatr* 65:195, 1980.

A new noninvasive bilirubinometer, the size of a 35 mm camera, which measures yellow color intensity of the skin with the ease of snapping a picture, was developed by the author and the Minolta Camera Company of Japan. A series of linear relationships were found to exist between total serum bilirubin concentration and yellowish skin color intensity in both term and low birth-weight Japanese infants. The author concluded that the Tc bilirubin measurement was precise and accurate, and will become an alternative to the routine clinical procedure in the near future.

Comment: Noninvasive technology in newborn medicine began in the 1970s. Transcutaneous PO_2 and PCO_2 monitors now are being used extensively in many newborn centers. The latest from Japan is a noninvasive transcutaneous bilirubinometer which promises to save time (one second per test), pain, blood letting and also cut laboratory expense. A word of caution is necessary at this experimental stage. Transcutaneous bilirubin readings may show accurate correlation with serum bilirubin in Japanese babies or white babies. However, it may not necessarily do so in black newborn infants. It is known that black premature babies are born with fair skin. The skin turns darker day by day. This certainly will affect the reading of Tc bilirubin. We currently are evaluating this machine in both black and white newborn infants. Our preliminary data show more scattered reading in black than in white infants. Tc bilirubin unfortunately does not correlate with serum bilirubin during phototherapy and soon after exchange transfusion. More information soon will be available in terms of its usefulness in the newborn nursery. I do not believe this machine will ever replace traditional serum bilirubin measurement but probably will serve the purpose of early screening and frequent (non-expensive) monitoring of jaundiced infants. (S. Sun, M.D.)

Piccone VA, et al: Prehepatic hyperalimentation. *Surg* 87:263, 1980.

A technique for prehepatic infusion of parenteral nutrients is described. Portal vein hyperalimentation allows hepatic modification and control of the infused nutrients before delivery of these substances into the general circulation and theoretically should reduce the incidence of metabolic complications of hyperalimentation. This technique was utilized in 40 *adult* patients for three to four weeks in each patient. Thrombosis of the portal vein did not occur. Candida was cultured from one umbilical catheter.

Comment: Umbilical vein catheterization and infusion of hyperalimentation solutions is a technique I use in some newborn infants under certain circumstances. To the best of my knowledge, this technique never has been used in older infants and children. I think this is an attractive method and could be considered after following the precautionary measures described in the paper. A study comparing prehepatic hyperalimentation with central hyperalimentation will be needed. (S. Saad, M.D.)

Craft WH, et al: High incidence of perinatal insult in children with idiopathic hypopituitarism. *J Pediatr* 96:397, 1980; **Miller WL, et al: Child abuse as a cause of post traumatic hypopituitarism.** *N Engl J Med* 302:724 (1980).

In most children with the syndrome of idiopathic hypopituitarism (IH) the hypopituitarism is the result of hypothalamic dysfunction. The reason for this dysfunction has not been clearly defined. Evidence (retrospective) is strong that the hypothalamic insult is often sustained in the perinatal period. Craft *et al*'s study reviewed patients with IH and compared them to controls. They demonstrated a substantially higher frequency of perinatal insults and neurologic abnormalities in IH. Miller and colleagues report 3 severely abused infants who developed IH. These infants had major head injury; they were subsequently placed in secure and supportive environments and failed to grow. Infants who have sustained a perinatal problem or who have had head injuries must be considered at risk for IH.

Comment: These two papers provide good evidence that IH may be an acquired disease related to CNS injury either at time of birth or in early infancy. (R. Rapkin, M.D.)

White JR et al: Small airways dysfunction in nonsmokers chronically exposed to tobacco smoke. *N Engl J Med* 302:720, 1980; **Lenfant C, et al: (Passive) smokers versus (voluntary) smokers. (Editorial)** *N Engl J Med* 302:742, 1980.

Non-smokers chronically exposed to tobacco smoke had unequivocal evidence of decreased pulmonary function, compared to controls. Light smokers (< 10 cigarettes per

*Abstracted from *Department of Pediatrics Newsletter*, CMDNJ, New Jersey Medical Schoool, Newark—Vol. 2, No. 5 (May) 1980. Selections are made by Richard H. Rapkin, M.D., Professor of Pediatrics and Medical Director of Children's Hospital, Newark, who is editor; Franklin C. Behrle, M.D., Professor and Chairman of Pediatrics; and Shyan C. Sun, M.D., Associate Professor of Pediatrics and Director, Department of Neonatology, Children's Hospital, Newark, who are coeditors. Comments are prepared by them and their associates.

day) or non-inhalers (including cigar and pipe smokers) had the same degree of disability as these "passive" smokers. Heavy smokers were clearly the most disabled. Other workers have demonstrated that children in households with smoking parents had reduced pulmonary function. Although the findings are significant and the studies elegant and flawless, there is now no absolute proof that these pulmonary function abnormalities have clinical significance.

Comment: C'mon! We all know that smoking is bad for us as individuals and now good solid data show that it's bad for our neighbors. Smoking in my house, class, office by anyone is forbidden. (I've given up my pipe.) We all need to be vigorous in protecting ourselves, our friends, families, colleagues, our fellow-man. Tobacco smoke, like antibiotics, has effects which extend beyond the individual.

(R. Rapkin, M.D.)

Steichen, JJ, et al: Osteopenia of prematurity. *J Pediatr* 96:528, 1980.

Extrauterine bone mineralization of prematures fed currently available formulas lags significantly behind intrauterine mineralization. Subclinical osteopenia (decreased mineralization) is frequent in premature babies and may become overt. Supplemental vitamin D with breast milk or formula has not prevented this. Osteopenia is probably due to mineral deficiency and calcium and the phosphorus content of formulas fed to low birth weight infants may need to be increased. In 13 infants fed a modified formula (increased Ca, P) normal mineralization (which was comparable to intrauterine mineralization) occurred. This was significantly greater than in control infants fed usual formulas.

Pussell BA, et al: Complement deficiency and nephritis. *Lancet* 1:675, 1980.

A family is reported with the association of C_3 complement deficiency and nephritis. There appeared to be a clear relationship between the deficiency and nephritis with the former the basis for the latter, rather than vice versa. Complement deficiency has been known to cause some cases of immune complex disease (e.g., H-S purpura, LE). The association has been thought to be spurious. However ". . . a substantial amount of clinical evidence has now accumulated to suggest that deficiency of complement function is itself responsible for the predisposition to immune complex disease in subjects with complement deficiency."

Comment: The association of some varieties of nephritis with complement depletion is well known. That complement deficiency can predispose to nephritis was not well known but now is a fact. Studying families of patients with autoimmune disease will help in our understanding of these associations.

Darlington RB, et al: Preschool programs and later school competence of children from low-income families. *Science* 208-202, 1980; **Casey PH, et al: Effect of the pediatrician on the mother-infant relationship.** *Pediatr* 65:815, 1980.

Low income children who attended infant and preschool programs in the 1960's were followed and compared to control groups. Eight separate research projects were analyzed. Children who had preschool programs (varying curricula and styles including Bank-Street, Piagetian, Montessori, Bereiter-Engelmann, and so on) had significantly higher rates of school achievement with lower frequency of need for special education and of being held back.

In another study mothers who received special developmental guidance during the first 6 months of their infants lives had increased sensitivity, interaction skills and appropriateness of play. Their infants had higher vocal imitation skills. All were in comparison to matched controls and were assessed by blinded techniques.

Comment: The article published in *Science* will become one of the most important educational pieces of data of the decade. It shows conclusively that preschool intervention of varying types makes a substantial difference in low income families. It contradicts other less careful studies of the past. The second article, although far less comprehensive, demonstrates the essence of pediatrics—education and guidance of young parents in appropriate child rearing—and shows that it is of value. What a feast.

Tetsuro F, et al: Artificial surfactant therapy in hyaline membrane disease. *Lancet* 1:55, 1980.

Previous attempts to administer pulmonary surfactant by aerosol have failed. Dr. Fujiwara from Japan has developed an artificial surfactant derived from cows' lungs and enriched with surface active phospholipids. His group instilled this material via endotracheal tube into the lungs of 10 newborn infants with severe hyaline membrane disease. Soon after the procedure, oxygenation and $AaDO_2$ improved and O_2 requirement decreased. Acidosis and systemic hypotension were resolved and many of the radiological abnormalities resolved. Eight infants survived. The authors claimed that postnatal tracheal instillation of artificial surfactant may prove a useful treatment for severe hyaline membrane disease.

Comment: Hyaline membrane disease remains the number one killer of preterm infants. Attempts to replace missing or insufficient surfactant have not been successful. This is the first demonstration in the human of a dramatic success after only a simple instillation of an artificial surfactant. If the authors' claims are true, this is certainly an historic event. Further study is necessary in terms of refinement of artificial surfactant and technique of administration. Dr. Fujiwara has done one of the most important studies and will surely stimulate further work in this area. (Z. Chen, M.D.)

Editor's Comment: This article was previously reviewed. Its importance may have escaped some of you and I am repeating its review to call your attention to it again.

(R. Rapkin, M.D.)

Kattan M., et al: Corticosteroids in status asthmaticus. *J Pediatr* 96:596, 1980.

In a randomized controlled study, hydrocortisone IV with conventional therapy in non-steroid using asthmatics, admitted for status, did not provide any advantage over conventional therapy alone. These data, from a limited number of patients, do not support the routine use of steroids in acute status asthmatics.

Comment: What to do? In a previous newsletter I quoted a recent review which suggested steroid usage in all status and now this study. I guess that if this study is confirmed by a much larger one, then one can conclude that its results are valid. In the meantime it is the practitioner's choice. I would opt for short-course steroids in any severely ill acute asthmatic, especially those with elevated pCO_2s. The above study included only mildly ill children (average pCO_2 36, average pH 7.40).

Knudson RP, et al: Neonatal heelstick blood culture. *Pediatr* 65:505, 1980

Heelstick blood cultures (0.2 ml collected into sterile capillary tubes) were demonstrated as sensitive as venous blood cultures in the diagnosis of sepsis.

Comment: Neonatal bacteremia usually has greater than 1000 organisms per ml of blood. The sensitivity of this method is five organisms per ml. Neonatal blood cultures by heelstick is ". . . safe, simple and . . . accurate in diagnosing neonatal sepsis . . ."

Ingram RM: The possibility of preventing amblyopia. *Lancet* 1:585, 1980.

Amblyopia occurs significantly often in the absence of squint if correction is not instituted in the sensitive period (first 18 months of life). In order to prevent it, hypermetropia must be detected early. Visual acuity testing cannot be done at this early age and therefore refraction must be explored as a means of screening. Two studies have been done which demonstrate its feasibility (*Br J Ophthalmol* 61:8, 1977; 63:288, 1979).

Albert R, et al: Guidelines for short course TB chemotherapy. *Morb Mort Wkly Rept* 29:97, 1980; **Reichman L: Tuberculin skin testing.** *Chest* 76S:764S, 1979.

Recent trials have demonstrated that considerably shorter courses of chemotherapy in TB are effective. CDC recommendations are that short course programs be instituted in the U.S. providing that all who embark upon such systematically collect data for analysis. If this is done then:

(1) A core chemotherapy regime using INH and Rifampin for at least nine months is acceptable for patients with uncomplicated pulmonary TB.

(2) The dose for children should be usual.

(3) After two weeks to two months of daily therapy, continuation can be either daily (if self administered) or twice weekly (if supervised).

(4) Extrapulmonary, drug resistant or patients with complicating medical conditions cannot be included in the short course regime.

(5) Patients should remain under surveillance for at least 12 months after completion of treatment.

The classification of TB has changed and the American Thoracic Society uses the following:

0 No exposure; not infected.
1 Exposure; no evidence of infection.
2 Infection; no disease.
3 Infection; disease.

In other words, class 0 is almost the entire population of the world (no exposure, PPD negative); class one is a PPD negative contact; class 2 is a PPD negative, well patient with a negative chest x-ray; and class 3 is a patient with clinical or x-ray TB.

Comment: Dr. Reichman carefully reviews the TB skin test and other aspects of the diagnosis of TB. This article, which probably will be overlooked by pediatricians, should be read carefully. He discusses Tine, false negative PPD's and BCG in an authoritative and comprehensive fashion (in 6 pages).

(R. Rapkin, M.D.)

Farrell MK et al: Epidemic influenza myopathy in Cincinnati in 1977. *J Pediatr* 96:545, 1980.

As the respiratory symptoms of Influenza (B) waned, lower extremity muscle pain occurred abruptly. CPK levels were high. Muscle biopsy confirmed rhabdomyolysis. All patients recovered in three to five days. Influenza B virus was cultured from the skeletal muscle of one patient.

Comment: This now well-known entity has been called influenza myositis or postinfection myositis.

(R. Rapkin, M.D.)

Singer WD, et al: The effect of ACTH therapy upon infantile spasms. *J Pediatr* 96:485, 1980.

Infantile spasms (flexor or extensor with hypsarrhythmia on EEG) are of unknown etiology and poor prognosis. Treatment has been disappointing. ACTH given soon after onset of the disorder is clearly efficacious in reducing spasms. Since treatment outcome appears related to beginning the therapy as soon as possible after onset, the authors consider diagnosis and treatment a medical emergency. No evidence is presented about developmental outcome.

Brook I: A practical technique for tympanocentesis. *Pediatr* 65:626, 1980.

A technique is described using an intravenous cannula set which is adaptable to office practice. The ear canal is cleaned with a blunt curette and then swabbed with povidone iodine solution followed by saline irrigation. It is dried with sterile swabs and a culture of the canal is obtained. An IV cannula (18 or 20) attached to a two ml syringe is used. The needle is bent at its hub. The covering is retracted and the needle pushed through the posterior inferior quadrant of the TM. Negative pressure is applied to the syringe.

Comment: This simple procedure allows its wider use.

Heroman WM, et al: Adrenal suppression and Cushingoid changes secondary to dexamethasone nose drops. *J Pediatr* 96:500, 1980.

Despite the absence of adequate studies, steroid nose drops have been used to improve eustachian tube dysfunction. A child is described who had the above side effects.

Comment: Let us continue to point out the dangers of manipulating children without data to substantiate the therapy. How careless (I wanted to say "callous") we are to "try" things on patients without evidence. Intentions, however good, are not enough. (R. Rapkin, M.D.)

Redman JF, et al: Uroradiographic evaluation of the enuretic child. *J Urol*122:799, 1979.

Twenty-one of 138 children with enuresis had an anatomic abnormality. All 21 had infection, history of infection or clear-cut obstructive signs. Unless there is infection or obstructive signs, radiography is unnecessary.

Comment: The editors comment: ". . . x-ray assessment is not required unless infection has been documented. Hopefully, the days of a complete urologic study for enuresis alone are history." (R. Rapkin, M.D.)

Rickwood AMK, et al: Primary vesicoureteric reflux (VUR) in neonates with imperforate anus. *Arch Dis Child* 55:149, 1980.

Twelve of thirty-three neonates with imperforate anus had VUR. Nine of the 12 had a totally normal IVP despite severe VUR, which was seen on voiding cystourethrogram (VCU).

Comment: Children with imperforate anus should have IVP and VCU. The most important lesson from this paper, I believe, is that a normal IVP does not rule out urinary anomalies in an infant. A VCU is mandatory in the radiographic assessment of the urinary tract of infants with suspected anomalies (e.g., those who have had documented UTI or who have imperforate anus). (R.Rapkin, M.D.)

THERAPEUTIC DRUG INFORMATION

This information is compiled by the Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Arnold and Marie Schwartz College of Pharmacy and Health Sciences, Long Island University.*

1. Is there a significant drug-drug interaction between valproic acid and phenytoin?

Official literature for valproic acid (sold as Depakene®) states there is conflicting evidence regarding an interaction with phenytoin (sold as Dilantin®), and it is unknown if this results in a change in free phenytoin serum concentrations[1].

Monks *et al*[2] reported phenytoin was displaced *in vitro* from serum albumin binding sites by therapeutic range concentrations of valproic acid. Displacement of phenytoin appeared to increase proportionately with increased concentrations of valproic acid.

Vakil and co-workers[3] reported initial reduction of plasma phenytoin levels in patients taking valproic acid in low doses. Monks and Richens[4] described effects of single doses of sodium valproate on serum phenytoin levels and protein binding in six epileptic men. No significant clinical changes occurred. Total serum phenytoin levels fell due to reduced bound drug, but free (active) serum phenytoin rose slightly.

In conclusion, *in vitro* and *in vivo* studies suggested phenytoin was displaced by valproic acid from albumin binding sites[2,4]. This appeared not to be clinically significant. Although total serum phenytoin levels may be reduced, the free serum levels are not and thus the dose of phenytoin shouldn't be mistakenly increased.

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2. What is the recommended influenza vaccine for the 1980-1981 season, and its recommended schedule for vaccination?

The Advisory Committee on Immunization Practices of the U.S. Public Health Service reviews the formulation of influenza vaccine regularly. Reformulation of the vaccine is recommended, as needed, to counter major antigenic changes and antigenic drifts.

In 1979-80, the influenza vaccine in use was trivalent, containing three antigens—A/Brazil/78 (H_1N_1), A/Texas/77 (H_3N_2), and B/Hong Kong/72. The predominant strain of influenza virus in the United States during this period was B/Singapore/79, a variant of the prototype B/Hong Kong/72.

The vaccine recommended by the U.S. Public Health Service for use during the 1980-81 season will also be trivalent, consisting of inactivated preparations of antigens representative of influenza viruses expected to be prevalent: A/Poland/Brazil/78 (H_1N_1), A/Bangkok/79 (H_3N_2), which is a variant of A/Texas/77, and B/Singapore/79. The formulation will contain seven micrograms of hemagglutinin of each antigen in each 0.5 ml dose. Persons 28 years and older will require only one dose, since most persons in this age group have already been exposed to the viruses. Because of lack of previous contact with H_1N strains, persons less than 28 years of age who did not receive at least one dose of the 1978-79 or 1979-80 trivalent vaccine will require two doses of the 1980-81 vaccine, administered at least four weeks apart. Those who received the 1978-79 or 1979-80 vaccine will require only one dose. The vaccine will be available as whole virion (whole virus) and sub-virion (split-virus) preparations. Since the split-virus vaccines have been shown to produce fewer side effects than whole virus vaccines in children, only the split-virus vaccines are recommended for persons less than 13 years of age. Children between three and 12 years of age should receive two doses of 0.5 ml, each administered at least four weeks apart, while children between six and 35 months old should receive 0.25 ml over the same dosage schedule. However, since the likelihood of febrile convulsions is greater in the latter age group, special care should be taken in weighing relative risks and benefits.

Annual vaccination is strongly recommended for all individuals at increased risk of adverse consequences from infections of the lower respiratory tract. Conditions predisposing to such risk include: (1) acquired or congenital

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*The center serves as a source of intelligence on therapeutic and pharmaceutic information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists: Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clincal Pharmacy, Arnold and Marie Schwartz College of Pharmacy and Health Sciences, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 5 p.m.—telephone (212) 622-8989 or 330-2735. Responses to these questions were prepared by J.M. Rosenberg, Ph.D., Pharm. D.; H. Boothe, B.S. Pharm.; M.J. Berger, R.Ph.

heart disease associated with altered circulatory dynamics; (2) any chronic disorder with compromised pulmonary function; (3) chronic renal disease; (4) diabetes mellitus and other metabolic diseases with increased susceptibility to infection; (5) chronic, severe anemia; and (6) conditions which compromise the immune system.

Vaccination is also recommended for older persons, particularly those over age 65, because excess mortality in influenza outbreaks occurs in this age group.

In considering vaccination of persons who provide essential community services or who may be at increased risk of exposure, such as medical care personnel, the inherent benefits, risks and cost of vaccination should be taken into account.

Since influenza vaccine is an inactivated viral preparation, it probably does not pose any special maternal or fetal risk, when administered during pregnancy.

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3. Do you have information on ritodrine for inhibiting premature labor?

Ritodrine, under investigation by Philips-Duphar Co., stimulates $beta_2$ adrenergic receptors. It causes dose-dependent inhibition of contractions of preterm and postpartum human uterus. In recent clinical studies, it decreased incidence of preterm labor in 70 to 80 percent of patients compared to 40 to 50 percent of women treated with bedrest and sedation.[1-4]

Bieniarz *et al*[5] reported ritodrine administered intravenously successfully inhibited preterm labor in four multi-fetal pregnancies. Another patient misdiagnosed as exhibiting false labor and not treated, lost three of four premature babies. The authors recommended initial ritodrine treatment by intravenous route followed by oral route because of tendency of recurrences of premature labor.

Spellacy *et al*[6] conducted a randomized, placebo-controlled study involving treatment of premature labor with ritodrine. Twenty-nine women of similar age, parity, weight, gestational age and cervical changes were included. Drug and placebo were first administered by intravenous infusion and oral treatment was begun 24 hours later. Although the drug produced a beneficial effect in stopping premature labor, there was no significant increase in birth weight or infant survival for ritodrine-treated patients.

Humphrey[7] in a double-blind, placebo-controlled trial studied effects of intravenously administered ritodrine on fetal respiratory acidosis (associated with fetal asphyxiation), occurring during second stage of labor. The drug exerted beneficial effects presumably by increasing fetal blood flow through placenta resulting in greater gas exchange and by decreasing uterine contractions and tone.

Brettes *et al*[8] studied effects of ritodrine and placebo on uterine blood flow and maternal cardiovascular system during third trimester of pregnancy. Data suggested ritodrine increased uteroplacental blood flow exerting a beneficial effect in treatment of pathologically complicated pregnancies.

Minor side effects associated with ritodrine therapy included palpitation, tachycardia, flushing, sweating, tremors, nausea and vomiting.[5-8] No serious side adverse effects occurred.

In conclusion, ritodrine appears effectively to inhibit preterm labor without producing serious side effects.

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DOCTORS' NOTEBOOK

Trustees' Minutes October 19, 1980

A regular meeting of the Board of Trustees was held on Sunday, October 19, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

President's Report . . . Accepted a report from the President which revealed that he had attended the Carrier Foundation Symposium (9/30-10/1) and meetings of Passaic County Medical Society (10/8), the Commissioner of Health Medical Advisory Committee (10/15)—where Commissioner Finley explained that the DRGs are being rederived and it is expected that the process will be completed by January 1981—the Gloucester County Medical Society (10/16) and the New Jersey State Nurses Association (10/17).

Headquarters Facility . . . Noted that the new roof on the headquarters building will be completed in early November and that it is expected that the office space for the Medical Underwriters will be completed by the first week in November.

. . . Authorized the Board of Trustees to borrow an additional $300,000 to meet the unanticipated expenditure for the roof replacement and the accelerated construction costs to ready the office space for the Underwriters in 1980, rather than in 1981 as originally planned, and empowered the President and Secretary to execute the necessary documents.

CMDNJ . . . Received a report from the President of the College of Medicine and Dentistry which included the following:

Medical Manpower Needs—Advance information indicates that the report of the Graduate Medical Education National Advisory Committee agrees with the predictions of New Jersey's own Advisory Graduate Medical Education Council that a more rational distribution of physicians according to specialty and location must be assured. The medical manpower situation in New Jersey differs from the nation as a whole in that the imminent cutoff of alien medical graduates on whom New Jersey long has relied and New Jersey's late start in establishing its own medical schools impedes the state's capacity to train physicians to meet its predicatable needs. CMDNJ is continuing to expand its undergraduate programs for several years until the capacity to graduate 382 physicians a year is reached. Concerning the GMENAC recommendation that medical schools reduce enrollment by ten percent, no plans have been made by CMDNJ to change the projected number of graduates per year. The College depends on the Department of Higher Education and the Department of Health to determine the needs for health manpower in New Jersey and these agencies have found no reason to change their projection.

Rutgers Medical School—Two new services were dedicated recently at RMS—the Levine Neurological Research Laboratories to aid in the study of diseases such as Parkinson's and Huntington's syndromes. The Middlesex General Hospital and RMS affiliation is continuing to develop and the areas which have opened are an 11-bed pediatric intensive care unit, services for open-heart surgery and end-stage renal dialysis.

Toxicology—Another area of current focus at CMDNJ is toxicology as it affects environmental and occupational health and with aid of the CMDNJ Foundation, DuPont, Exxon and Mobil toxicology programs are expanding in all of the schools. The Newark campus will have a clinical toxicology laboratory/center within the pharmacology department. The Graduate School of Biomedical Sciences will offer a master's level program in toxicology beginning in September 1981 and the School of Allied Health Professions is working with Montclair State College to initiate bachelor's level training for toxicological technicians. CMDNJ and Rutgers University are developing a joint Ph.D. program in this field.

Blood Banking—The College has convened a series of meetings on blood banking and some progress is reported.

Physicians-Dentist Loan Redemption Program—Only two students have applied to participate in the Physician-Dentist Loan Redemption Program since it was instituted more than a year ago. The connotation of "indebted servitude" seems to be attached to such a program.

Granting of MD Degrees—President of the College Bergen confirmed his opposition to the provision in MSNJ's charter (granted in 1825) which permits the Society the authority to award the degree of "Medicinae Doctor" and has communicated his position to the Board of Medical Examiners.

Family Practice Programs—The feeling of the faculty at the school seems to be that students can get exposure to family medicine in other programs of teaching at the school rather than develop a family practice division. The Advisory Council on Graduate Medical Education has approved a track in family medicine in the residency program at Beth Israel Medical Center (Newark).

New Jersey Hospital Association . . . Received a report from the President of the New Jersey Hospital Association which noted: (1) that the Health Care Administration Board recently had adopted a regulation concerning medical-surgical facilities which included a revised capital facilities allowance, utilizing a "target-bed" concept based on a statewide criteria of 85 percent occupancy (the proposal will be reviewed in February); (2) that the Hospital Association supports the position of the HSA and is opposed to the closing of any existing perinatal facilities; and (3) that a report on the mechanics of the DRGs recently completed by a public accounting firm will be evaluated by the Health Research and Education Trust, as will future reports on the makeup and social and political aspects of the DRGs.

Medical Society of New Jersey Student Association . . . Received a check in the amount of $1,545 for 1980-1981 dues for MSNJSA and noted that a medicolegal seminar for the Student Association will be conducted at the Executive Offices in Lawrenceville on November 14; also that representative students will attend the AMA Interim Meeting in San Francisco in December.

Committee on Impaired Physicians . . . Approved the following recommendation from the Committee on Impaired Physicians with the understanding that financing is to be sought from sources outside the Medical Society of New Jersey.

That the Board approve the job descriptions and proposal for a fulltime Executive Coordinator and Administrative Assistant for the Committee on Impaired Physicians.

Note: As directed by the Board a job description, setting forth the goals, duties and responsibilities and accountability of the executive coordinator was supplied by the Committee on Impaired Physicians.

AMA Delegation . . . Approved the following recommendations from the report of the AMA Delegation:

1. That the resignation of James S. Todd, M.D. Chairman of the delegation, be accepted effective October 19, 1980.
2. That Alfred A. Alessi, M.D., be seated as a full delegate for the 1980 interim meeting.
3. That Augustus L. Baker, Jr., M.D., be seated as an alternate delegate for the 1980 interim meeting.
4. That the remaining year of Doctor Todd's term (July and December 1981) be filled by election at the 1981 Annual Meeting of the House of Delegates of MSNJ.
5. That the existence of this vacancy be widely disseminated to the membership before the meeting of the Nominating Committee.
6. That the President, President-Elect, Secretary, and Executive Director of MSNJ attend AMA general functions (annual, interim meetings; leadership conferences) at Society expense.
7. That Ms. Diana C. Gore, Administrative Assistant, attend the same functions as in 6 above, at Society expense.
8. That administrative department heads not routinely attend AMA meetings, but be assigned to attend by Mr. Maressa depending upon the issues or programs to be considered, and their relevance to the Society.
9. That administrative department heads be encouraged to attend AMA leadership conferences, and the AAMSE meetings at Society expense.
10. That the Medical Society of New Jersey be more aggressive in presenting nominations for membership on the various councils and committees of the AMA.
11. That members of MSNJ not in official capacities be encouraged to attend AMA conventions and conferences.
12. That the delegation be authorized to produce a delegate manual or other such promotion for use at AMA conventions in anticipation of Doctor Todd's reelection—cost estimate $1,000-1,500 yearly. (The delegation plans to work in conjunction with the Public Relations Department in producing this manual.)

AMA Board of Trustees . . . Received a report from James S. Todd, M.D., AMA Trustee, on the following significant actions taken at the October meeting of the AMA Board of Trustees:

1. 1981 Fiscal Year Budget—approved a budget of $69,314,000, noting that $5.5 million was added to expenditures to account for inflation.

2. HRET of New Jersey—approved a $25,000 grant to HRET of New Jersey for participation in their DRG Project study.

3. Women Physicians in Organized Medicine—received a report from the Ad Hoc Committee on Women Physicians in Organized Medicine—a recommendation in the report calling for support of the Equal Rights Amendment will be presented to the AMA House of Delegates for consideration.

4. CME—a new Council for Medical Affairs will be formed to replace the Liaison Committee for Continuing Medical Education; the veto power will be eliminated and the administration of the new Council will be on a contractual basis—the contract for the first year will be assigned to the Council on Medical Specialty Societies who will have the responsibility for its staffing and funding. The Liaison Committee on Graduate Medical Education has been reorganized in essentially the same fashion.

5. JCAH—has appointed William S. Hotchkiss, M.D. and Robert T. Kelly, M.D., as its representatives to the Joint Commission on the Accreditation of Hospitals.

6. Graduate Medical Education National Advisory Committee (GMENAC) Report—noted the major recommendations of the first volume of the report: (1) reduce the number of those entering medical school by 10 percent of the 1987 level; (2) decrease the number of foreign medical school graduates who enter the country; (3) provide incentives for newly graduated physicians who enter residencies in certain specialties; (4) hold the number of physicians' assistants and nurse practitioners in training at the current level; (5) eliminate all federal and state financial assistance now given to United States medical students studying aboard; (6) discontinue the Fifth Pathway Program, (7) give GMENAC statutory authority to continue its work.

Long Range Planning and Development . . . Noted that the Committee on Long Range Planning and Development currently is investigating several proposals cited in the ASAE Evaluation Report for presentation to the Board at a later date. The reports on the evaluation report from the Editor of *The Journal* and the Society's staff have been referred to the Committee for review.

Audit Committee . . . Received the report of the External Auditors, Ernst and Whinney, along with the audited financial statements.

New Jersey Psychiatric Association . . . Deferred action on a request from the New Jersey Psychiatric Association concerning its opposition to certain rules being implemented by the Department of Human Services which the Association believes will have an adverse effect on the welfare of psychiatric patients hospitalized in New Jersey. An attempt is being made to clarify the legality of the actions of the Department of Human Services and when this information is available it will be given to the Board together with specific recommendations.

Congress on Medical Education and Licensure . . . Authorized the attendance at the Congress on Medical Education and Licensure, (April 23-25, 1981 in Chicago), with expenses paid, of the Chairman of the Committee on Medical Education, one other member of the Committee and Martin Johnson of the Society staff.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

Your Foundation has enjoyed the sponsorship of the Medical Society of New Jersey, as well as the New Jersey Association of Osteopathic Physicians and Surgeons. Both organizations reaffirmed their support at their annual meetings last Spring. Endorsement by each group includes an assessment of $20 per member. Assessments are a nuisance to all affected by them. The cost of membership in medical societies has, like everything else, risen during the past few years. To those who continue to support us by this method, we say thank you.

We agree with those who do not like assessments. Most of our colleagues do not like the forces of change which brought about the formation of the Foundation. PSRO was not a popular concept with the profession. While it has been modified by budget and regulations, the PSRO program is still very much alive in New Jersey. New Jersey Foundation for Health Care Evaluation is involved as the operating arm of the New Jersey Professional Standards Review Council.

Another unpopular topic is DRG. Diagnosis Related Groups are employed by the New Jersey Department of Health in its new prospective rate-setting system for all hospitalized patients. Twenty-six hospitals are on line now; 40 more will start next month. Our attitude on DRG has been stated many times. The validity of the system is unproved and its usefulness as a rate-setting method remains to be demonstrated. However, since the law and regulations exist, physicians should have input in the accuracy of the groups and the quality assurance aspects of the procedures. Reference has been made to the utilization review regulations under S-446. We feel that the PSROs should conduct this review. The Board of Trustees of the Medical Society of New Jersey recently has supported this idea. This does not imply total endorsement of DRG.

Prepaid health care also is lacking in popularity with many of our colleagues. The HMO movement is a reality, and is steadily gaining in the East. The IPA mode is a worthy alternative to the closed-panel HMO. The interest of government, labor and industry in prepaid arrangements is real. New Jersey Foundation for Health Care Evaluation has called attention to these developments, and our information services are available to those who are interested. We are not attempting to convert the practice of medicine. Traditional fee-for-service will always be the preferred method of doctor-patient relationships. Awareness of the thrust of alternative delivery systems is necessary.

A byproduct of utilization review, such as PSRO, is the identification of numbers of patients in acute care hospitals who are awaiting transfer to long-term care beds. A one-day survey last September was conducted by New Jersey Foundation for Health Care Evaluation with the cooperation of all of our PSROs. In 100 hospitals, over 1800 patients were ready for transfer to beds that were, for a variety of reasons, not available. Previous studies of this problem led to the formation by New Jersey Foundation for Health Care Evaluation of a Council on Care of the Aging. The New Jersey PSRO Council had referred this matter to the Foundation. With the steady rise in the percentage of senior citizens in this State, there is needed a method of making medical and supportive services available to them. A position paper on this matter has been developed by NJFHCE. It will be presented to the MSNJ Board shortly. This is a natural outgrowth of our involvement in peer review and utilization. Other topics and objectives will arise. So, while we may not like assessments, PSRO, DRG, HMO/IPA, HSA, and so on, these factors are present and each demands your attention. With your support, we intend to keep you informed and to represent the interest of the practicing physicians and their patients.

CMDNJ Notes*

Stanley S. Bergen, Jr., M.D.
President

The first half of the College's "Decennial Year" has been marked with the advancement of programs that are bringing progress in medical education, research and health services to all New Jerseyans.

A highlight in Central Jersey, has been the establishment of a new highly sophisticated intensive care facility for children, the only one of its kind in the area, at Middlesex General Hospital, New Brunswick, the primary teaching facility of CMDNJ-Rutgers Medical School. The facility, a pediatric intensive care unit for children up to 16 years of age, is equipped with the most modern monitoring and diagnostic instrumentation available. It provides services previously unavailable in a region extending into South Jersey, where cases generally have been referred to Philadelphia hospitals.

The unit consists of 11 beds: six for older children; four infant's cribs in enclosed "isolettes" with separate temperature controls, and a negative pressure isolation suite, which is a germ-free area for special cases. Each of the beds is equipped with separate vital-sign monitoring equipment for providing continuous "read-outs" on the heart, brain and respiratory systems. The unit also contains a cardiac output computer and special ventilators for breathing assistance.

A battery of health care professionals operates the unit on a 24-hour basis. The staff consists of a medical director, a corps of specially trained pediatric nurses, a pediatric-psychiatric nurse, social worker and pediatric residents. The unit also has the full support of a wide range of pediatric specialists from the medical school faculty and hospital staff. An open heart surgery program is in the planning stage and will operate also in conjunction with the unit.

Also at CMDNJ-Rutgers Medical School, a sophisticated research center for the study of neurological diseases was opened as part of the school's Department of Neurology. Consisting of two large laboratories, the new center is designed to be the base for research into such now incurable diseases as Parkinson's and Huntington's Chorea, and to serve as an educational base for postgraduate physicians and graduate students in the neurosciences. The facility was made possible through a $100,000 grant from the Mollie and Jerome Levine Fund. Mr. Levine, a former New Brunswick attorney now living in Florida, established the fund following the death of this wife, who had succumbed to a neurological disease.

In South Jersey, preparations were underway, as this issue of *The Journal MSNJ* went to press, for the opening of New Jersey's first Area Health Education Center (AHEC) program, which has been in planning and developmental stages for the past two years. The program, an $8-million Federal and State investment, is administered by CMDNJ and consists of a consortium of health

care and educational institutions in South Jersey. This important development for the most underserved section of the State will be reported in further detail in a future column.

An affiliation agreement has been entered between CMDNJ-College Hospital and the Rutgers University College of Nursing (RCN), Newark, with its goal the establishment of a major teaching center for nursing in Newark. The one-year contract, renewable annually, will strengthen the mutual commitment to health care services which already exists between the two State institutions. Under the affiliation agreement, it is estimated that at least 200 undergraduate and graduate students of RCN's 600-member student body, and their supervisors, will be placed into the College Hospital annually, but this number will vary at any time, depending on the size of each class.

Responsible for implementation of the agreement is a Nursing Liaison Council with four representatives from each institution. The affiliation is another fine example of how CMDNJ always has striven toward pooling of resources with other institutions, not only through the use of facilities but through the expertise of professionals to offer the finest health care and education possible.

Another major step in health care was taken at College Hospital with the inauguration of New Jersey's first comprehensive training program in emergency nursing. This innovative program, which consists of five separate training courses, is designed to prepare nurses for the care and management of critically ill and injured patients.

In the same vein, a $200,000 Federal grant to strengthen and further develop emergency medical services training and practices in New Jersey has been awarded to the CMDNJ-School of Allied Health Professions. The multifaceted, three-year grant, which is the third largest awarded annually, will help the school establish a regional model of emergency care practice and standard of performance. The first course began early last month, and other courses will be offered throughout the winter.

On the Newark campus, the Department of Pediatrics of CMDNJ-New Jersey Medical School dedicated its New Jersey Tay-Sachs Prevention Program, which offers free preventive medicine to all students enrolled in colleges throughout the State. The new center is the only facility in New Jersey to have its own laboratory for Tay-Sachs screening, and is one of the very few such centers in the United States. Handled by a medical team visiting the various colleges in the State, the screening process is made possible by the acquisition of an autoanalyzer enzyme assay machine capable of handling 60 blood samples per hour. Heretofore, laboratory work for the many Tay-Sachs screening programs sponsored by CMDNJ had been sent to a Brooklyn hospital.

Patient Package Inserts

In the September 12, 1980 *Federal Register,* FDA published its final rule regarding general procedures relating to the development and distribution of future patient package inserts (PPI) for prescription drug products. To be affected in the near future are ten named drugs and drug classes. **The regulations will not be effective with respect to a particular drug until 180 days after publication of a notice in the Federal Register applying the regulations to that specific drug (or drug class).** This memorandum will highlight the final PPI rule and review existing regulations.

NEW PPI RULE

Generally, PPIs are to be provided by dispensers, including physicians, except as noted below:

- The physician interdict—a physician prescribing a drug may direct (in handwriting on the prescription or orally to a pharmacist) that the dispenser withhold the PPI, and it can be withheld unless the patient specifically requests it. (Dispensing physicians are encouraged to provide the PPI, but need not do so unless the patient specifically requests it.);
- The emergency treatment exemption—a PPI need not be given to patients who receive a drug in the course of emergency treatment (in or out of an institutional setting);
- The health care institution options—health care institutions are required to devise a system to make PPI information available to patients on request; and
- PPIs only need be provided for the initial dispensing of the drug, not for refills. The PPIs will be provided to dispensers by each manufacturer and the PPI text will be included in the package insert (and PDR).

Published with the final rule were the FDA "guideline" PPIs for the ten drugs and drug classes for which patient labeling (PPIs) will be required during the "initial program": ampicillins, benzodiazepines, cimetidine, clofibrate, digoxin, methoxsalen, propoxyphene, phenytoin, thiazides, and warfarin. It is intended that a three-year evaluation will take place as to these drugs before PPIs are extended to apply to other drugs.

AMA is preparing comments on each of the "guideline" PPIs identified above. Other persons interested in commenting may write to the following address to receive copies of the documents and may submit comments before October 27, 1980: FDA Commissioner, Jere E. Goyan, Ph.D., c/o Hearing Clerk (HFA-305), Food and Drug Administration, Room 4-62, 5600 Fishers Lane, Rockville, MD 20857.

CURRENT PPI RULES

The new PPI rule does not change the current requirements regarding prescription drugs for which PPIs already may have to be dispensed pursuant to regulations in effect for some time. Drugs covered include:

- Isoproterenol inhalation drug products
- Oral contraceptive drug products
- Oral postcoital contraceptive drug products
- Medroxyprogesterone acetate injection drug products
- Intrauterine devices
- Estrogenic drug products
- Progestational drug products

The existing regulations on estrogenic and progestational drug products, for example, require that the patient labeling be "dispensed" to *all* (but cancer therapy) *patients each time the drug is dispensed.* The requirement pertains to dispensing physicians, as well as to pharmacists, and to institutional and outpatients. Additionally, the existing format and content of PPIs for these regulated products will remain unchanged, though the new PPI rule and FDA "guideline" PPIs for the (10) drugs to be covered call for the dissemination of substantially altered patient labeling.

PPI PHYSICIAN Q AND A

1. Q. Must I give a PPI to my patient each time I dispense a drug for which a PPI is printed?

A. That depends on the drug. If it is a drug for which a PPI is available but not yet *required* by FDA (i.e., propoxyphene), dispensing of the PPI is discretionary. Even when the new FDA rule is

explicitly extended to each of the 10 drugs to be covered, physician dispensing of a PPI will still be discretionary *unless the patient requests it.*

Drugs such as estrogenic and progestational products for which PPIs are *now required* by FDA should be dispensed with the approved PPI.

2. Q. Who will provide the PPIs?

A. Drug manufacturers and distributors are required to provide dispensers with adequate supplies of PPIs. The PPI text also will be incorporated into the package insert (and PDR).

3. Q. Will foreign language PPIs be available?

A. FDA has urged drug manufacturers to create PPIs written in Spanish as well as English. However, providing the English version of a PPI is sufficient to comply with the current and new PPI rules.

4. Q. When the new rule becomes effective with respect to a particular drug, (a) What must I do in order to assure that the patient receives the PPI? (b) Can I direct that a pharmacist *not* dispense the PPI to a particular patient?

A. (a) Nothing. The pharmacist must dispense the PPI unless directed otherwise by the prescriber. (b) A prescriber may direct over the phone or *in his/her own handwriting on the prescription form* that a PPI *not* be dispensed. The PPI will not be dispensed, unless the patient specifically requests it from the pharmacist.

5. Q. What about my hospitalized patients?

A. Health care institutions, including hospitals and nursing homes, will be required to inform patients of the availability of PPI information, but need only supply it *on request.*

6. Q. Are there penalties for not dispensing required PPIs?

A. Yes. Failure to dispense a PPI for which there is an established (non-discretionary) dispensing requirement could be treated by FDA as the dispensing of a "misbranded" drug. Penalties for distributing misbranded drugs are provided in the Federal Food, Drug, and Cosmetic Act.

Remember, however, that physician dispensing of PPIs under the new rule will be discretionary. Physicians are encouraged by FDA to use the PPI in the course of patient instruction, but are not required to use the PPI unless the patient requests it.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Eric J. Schenkel, M.D., Park Drive Manor, Apt. A-1212, Philadelphia, PA 19144. Einstein 1976. Also, general internal medicine. Board certified (IM). Group, partnership, academic. Available August 1981.

CARDIOLOGY—James Liguori, M.D., 417 Union Avenue, Scotch Plains, NJ 07076. CMDNJ 1976. Board certified. Trained in all invasive and non-invasive techniques. Group, partnership, solo. Available July 1981.

Sheldon Eisenberg, M.D., 300 Community Drive, Manhasset, NY 11030. Cornell 1976. Also general internal medicine. Board certified (IM). Non-invasive techniques, hospital based, or single or multi-specialty group. Available July 1981.

Richard J. Butcher, M.D., Geisinger Medical Center, Danville, PA 17822. University of Pennsylvania 1973. Board certified (IM). Group or partnership. Available July 1981.

FAMILY PRACTICE—C. Chin, M.D., 1016 Washington Garden Apts., Washington, NJ 07882. SUNY-Stonybrook 1979. Board certified. Part-time clinic, ER or housestaff duty. Available.

Mark Scheier, M.D., 24 Paerdegat Third Street, Brooklyn, NY 11236. Guadalajara (Mexico) 1977. Board eligible. Group, partnership, multi-specialty group. Available July 1981.

Winthrop C. Dillaway, III, M.D., 322 W. 57th Street, Apt. 45-L, New York, NY 10019. Guadalajara (Mexico) 1975. Board certified. Solo (home office). Available.

Stephen Kay, M.D., 22745 Kelly, East Detroit, MI 48021. Innsbruck (Austria) 1949. Board eligible. Solo. January 1981.

GASTROENTEROLOGY—Jacques M. Schmid, M.D., 225-F Edgemoor Road, Bridgeport, CT 06606. Einstein 1976. Also general internal medicine. Board certified (IM). Any type practice. Available July 1981.

GENERAL PRACTICE—Kirit D. Trivedi, M.D., 546 West Ridgeway Street, Warrenton, NC 27589. Baroda (India) 1967. Board certified. Partnership or group. Available June 1981.

Martin L. Schlein, M.D., 106 Merrifield Court, Greenville, SC 29615. Tel Aviv (Israel) 1973. Group, partnership, solo. Available.

INFECTIOUS DISEASES—David Brooks, M.D., P.O. Box 33172, San Diego, CA 92103. Dublin (Ireland) 1962. Also general internal medicine. Available.

INTERNAL MEDICINE—Lee A. Frankel, M.D., 63-B Cowperthwaite Street, Danbury, CT 06810. Guadalajara (Mexico) 1977. Board eligible. Solo, partnership, group. Available July 1981.

Brijinder Singh Kochhar, M.D., 8501 Fort Hamilton Parkway, Apt. 2-A, Brooklyn, NY 11209. Patiala (India) 1970. Also, pulmonary medicine. Board certified. Any type practice. Available July 1981.

John R. Kalloz, M.D., 109 Green Street, Danville, PA 17821. Pennsylvania State 1978. Board eligible. Single or multi-specialty group. Available July 1981.

Ramulu Eligeti, M.D., Deborah Heart & Lung Center, Browns Mills, NJ 08015. Osmania (India) 1972. Subspecialty, cardiology. Solo or partnership. Available July 1981.

Ben Praport, M.D., 14 Country Club Lane, Elizabeth, NJ 07208. Israel 1975. Subspecialty, gastroenterology. Board eligible. Any type practice. Available July 1981.

Mohammad Razavr Rahman, M.D., 309 Birchwood Court, North Brunswick, NJ 08902. Dow (Pakistan) 1974. Board eligible. Group, solo, institutional. Available.

M. S. Chakrabarty, M.D., 155 East Godfrey Avenue, Ashbourne Manor, E-506, Philadelphia, PA 19120. Grant Medical (India) 1972. Subspecialty, gastroenterology. Board certified. Solo, partnership, group. Available July 1981.

David J. Stone, M.D., 105 Stewart Circle, Charlottesville, VA 22903. NYU 1974. Board eligible. Group. Available July 1981.

Howard Allen Sackel, M.D., 39 Cottonwood Drive, Stoughton, MA 02072. SUNY-Upstate 1976. Subspecialty, nephrology. Board certified. Group or partnership. Available July 1981.

Sharon D. Warner, M.D., 115 Old Short Hills Road, Apt. 274, West Orange, NJ 07052. SUNY-Downstate 1978. Board eligible. Partnership, single or multi-specialty group. Available July 1981.

NEPHROLOGY—Krishnababu Chunduri, M.D., 2121 Shore Parkway, Apt. 2-F, Brooklyn, NY 11214. Guntur (India) 1973. Board eligible. Solo or group. Available January 1981.

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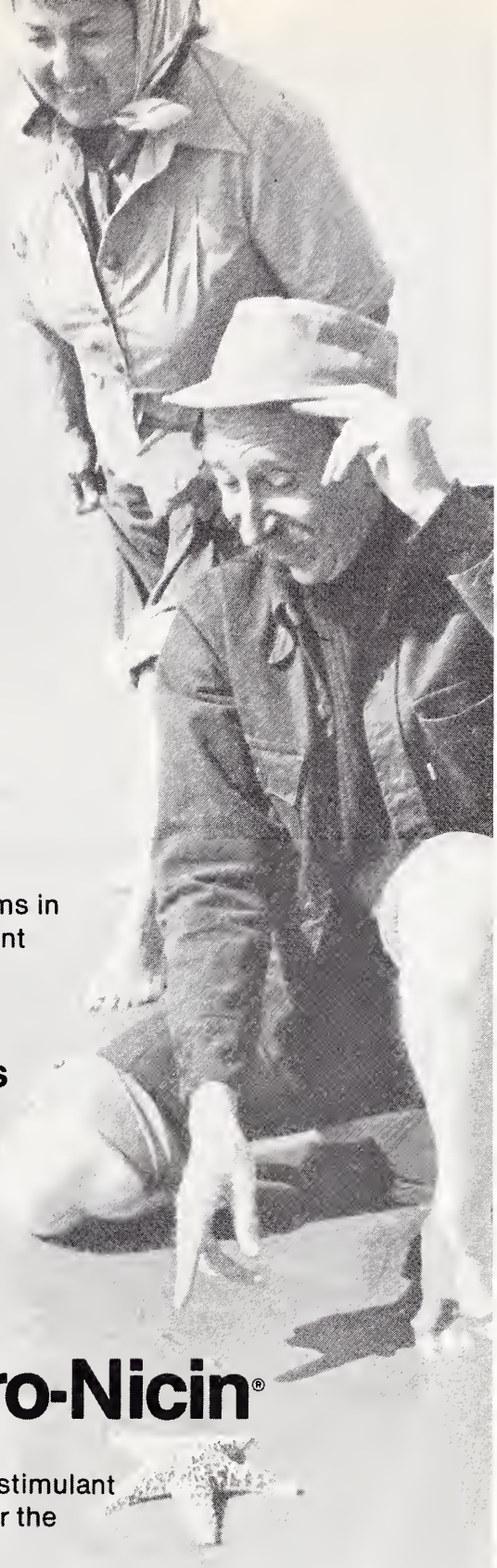

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OBSTETRICS/GYNECOLOGY—T. L. Sharpe, M.D., 8309 SW 107th Avenue, Apt. D, Miami, FL 33173. Miami 1977. Board eligible. Group or partnership. Available July 1981.

ONCOLOGY—Pratima D. Parikh, M.D., 16 Wakeman Street, West Orange, NJ 07052. M.S.U. (India) 1973. Board eligible. Group, partnership, solo. Available.

D. S. Prajapati, M.D., 88 Slate Creek Drive, #5, Cheektowaga (Buffalo) NY 14227. Baroda (India) 1972. Board certified. Group, partnership, solo. Available July 1981.

Steven E. Zimmerman, M.D., 7562 Westlake Terrace, Bethesda, MD 20034. Cornell 1976. Also, general internal medicine. Board certified (IM). Group or partnership preferred, also solo. Available July 1981.

OPHTHALMOLOGY—Mark Gorovoy, M.D., 1661 Kenwood Avenue, Alexandria, VA 22302. George Washington 1977. Board eligible. Any type practice. Available July 1981.

OTOLARYNGOLOGY—Samir M. Geleil, M.D., 94 Amity Street, Apt. 3-F, Brooklyn, NY 11201. Cairo (Egypt) 1965. Board eligible. Solo or group. Available July 1981.

PATHOLOGY—Kung N. Rho, M.D., 5601 Boulevard East, Apt. 22-I, West New York, NJ 07093. Chonnam (Korea) 1959. Both AP/CP. Board eligible. Full or part-time group, institutional, or partnership. Available July 1981.

Kamini P. Vaidya, M.D., 956 Woodland Avenue, Oradell, NJ 07649. M.S.U. (India) 1971. Board certified (both AP and CP). Group, partnership, hospital. Available.

Syed A. Hadi, M.D., 162 N. Heck Hill Road, Saint Paris, OH 43072. Osmania/Gandhi (India) 1963. Board certified (AP), board eligible (CP). Any type practice. Available.

Kaushik J. Pandya, M.D., 30-49 70th Street, Jackson Heights, NY 11370. Baroda (India) 1974. Any type practice. Available July 1981.

Maneala V. Betkerur, M.D., 10015 S. Hill Terrace 28/202, Palos Hill, IL 60465. Karnatak (India) 1974. Subspecialty, neonatology. Board certified. Group, institutional. Available July 1981.

Aiylam P. Sivaramakrishnan, M.D., 3520 Keystone Avenue, #3, Los Angeles, CA 90034. Seth G. S. Medical (India) 1971. Subspecialty, pediatric cardiology. Board certified. Group, institutional, hospital-based, HMO. Available.

Sitamahalakshmi Nutakki, M.D., 22 Metropolitan Oval, #5G, Bronx, NY 10462. Guntur (India) 1970. Board eligible. Group or partnership. Available January 1981.

RADIOLOGY—U. Chaibongsai, M.D., 992 Woodmere Drive, Westfield, NJ 07090. Siriraj (Thailand) 1968. Board certified. Part-time, group, partnership. Available.

RHEUMATOLOGY—John Guttell, M.D., 37 Putnam Road, Foxboro, MA 02035. NYU 1976. Board certified. Group or partnership. Available July 1981.

Michael A. Friedman, M.D., 135 Loblolly Lane, Chapel Hill, NC 27514. Wisconsin. Board certified. Group, partnership, solo, hospital-based. Available July 1981.

Thomas A. Giangrasso, M.D., 3550 Jeanne Mance, Apt. 2402, Montreal, Quebec, Canada H2X 3P7. Medical College of PA 1975. Subspecialties, allergy/immunology. Board certified (also IM). Any type practice. Available July 1981.

SURGERY, GENERAL—Zahur U. Azhar, M.D., 1684 Central Avenue, Bridgeport, CT 06610. Nishtar (Pakistan) 1963. Board eligible. Solo. Available July 1981.

Dariush Vaziri, M.D., 7510 Brompton Court, Apt. 587, Houston, TX. Tehran (Iran) 1974. Also, vascular surgery. Board eligible. Group, partnership. Available August 1981.

SURGERY, ORTHOPEDIC—Steven H. Fried, M.D., The Hospital for Special Surgery, 535 East 70th Street, New York, NY 10021. Rutgers 1975. Any type practice, plus part-time faculty position. Available July 1981.

Inder J. Singh, M.D., WCMC #1-C Beachwood Hall, Valhalla, NY 10595. K.G. Medical, Lucknow (India) 1968. Solo or partnership. Available July 1981.

Mark M. Kramer, M.D., 3450-12 Wayne Avenue, Bronx, NY 10467. Vanderbilt 1976. Board eligible. Private practice. Available July 1981.

SURGERY, VASCULAR—Pramod Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969. Board certified. Solo, group, associate. Available June 1981.

UROLOGY—Vijay S. Athani, M.D., 2009 Trent Court Apartments, Lindenwold, NJ 08021. L.T. Med. College (India) 1970. Board eligible. Solo, partnership. Available.

Elliott Lieberman, M.D., 16-66 Bell Boulevard, Apt. 730, Bayside, NY 11360. SUNY-Downstate 1976. Group or partnership. Available July 1981.

William Kohlberg, M.D., 3450-17A Wayne Avenue, Bronx, NY 10467. Pittsburgh 1975. Board eligible. Group or partnership. Available July 1981.

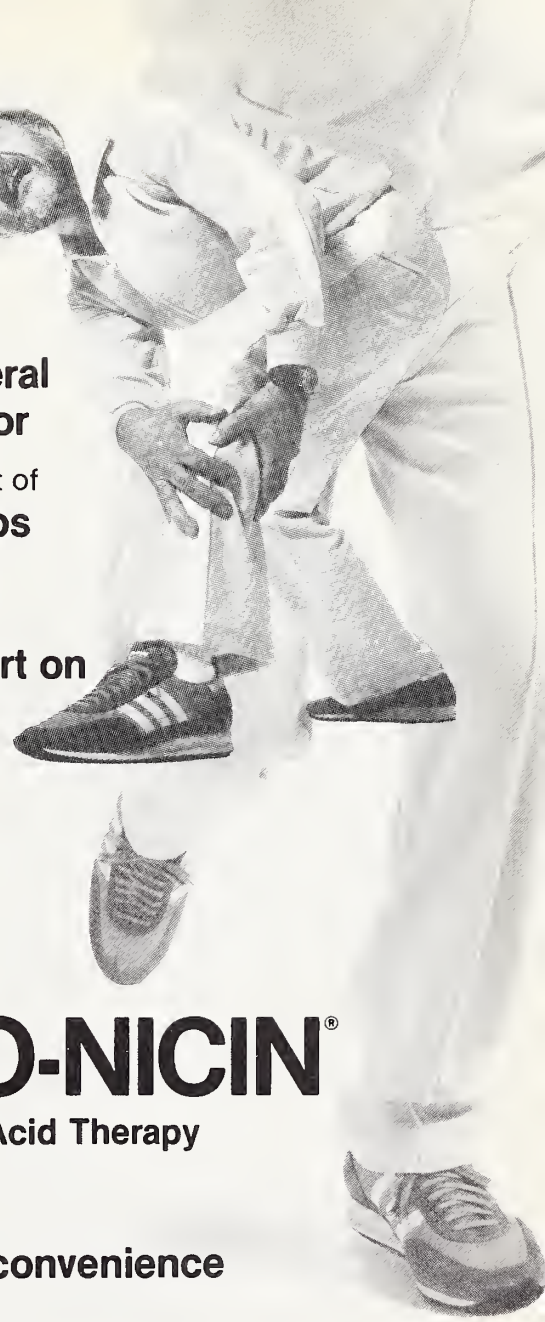
Paul A. Church, M.D., 435 East 70th Street, Apt. 27-C, New York, NY 10021. Cornell 1975. Board eligible. Solo, partnership, group. Available June 1981.

Vasant Betkerur, M.D., 10015 South Hill Terrace, 28/202, Palos Hill, IL 60465. Government Medical (India) 1973. Solo, partnership, group. Available 1981.

Harvey Schoenbrum, M.D., 1249 Park Avenue, Apt. 14-A, New York, NY 10029. Pittsburgh 1976. Board eligible. Group, partnership. Available July 1981.

Donald M. Bergner, M.D., 8300 Palmetto Street, Apt. 30, New Orleans, LA 70118. Bowman-Gray 1976. Board eligible. Group, partnership, multi-specialty. Available June 1981.

Jerome Patrick Parnell, M.D., 435 East 70th Street, Apt. 28-C, New York, NY 10021. SUNY-Downstate 1974. Board eligible. Partnership or group. Available July 1981.



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PERSONAL ITEM

Dr. Novich Honored

The City of Perth Amboy and the Pulaski Citizens Club honored Max M. Novich, M.D., at a reception on October 25, 1980, for his recent selection as an Honorary Member of the World Boxing Hall of Fame. Dr. Novich started practicing his specialty of orthopedics and sports medicine in Perth Amboy in 1954 and has been serving the people of this and other areas ever since.

Dr. Novich is a surgeon, author, and specialist in sports-related injuries; he is a pioneer in the rapidly expanding specialty of sports medicine. He was an outstanding boxer in his intercollegiate days, and competed in the Olympic Golden Gloves in 1936. During World War II he served (as captain, after a battlefield promotion) in the U.S. Army Medical Corps, was wounded in battle, and received the Purple Heart, the Bronze Star, and four Battle Participation Stars.

Dr. Novich is a Diplomate of the American Board of Orthopaedic Surgery, a Fellow of the American Academy of Orthopedic Surgeons, Clinical Professor of Surgery and Director of the Division of Sports Medicine at CMDNJ/New Jersey Medical School, Director of Sports Medicine at the United Hospitals Orthopedic Center, and physician to olympic boxing teams. He was ringside physician at the 1968 Mexico City Olympics, 1972 Munich Olympics, and 1976 Montreal Olympics. He was chief physician for the 1965, 1969, and 1973 U.S. Maccabiah Teams, consultant in boxing on the President's Commission on Olympic Sports, and physician to the New Jersey AAU Boxing and Golden Gloves Championships. He was selected as one of the 60 top athletes in the history of University of North Carolina intercollegiate athletics. He has been a team physician for New Jersey high schools since 1946. He is on the Board of Directors of the New Jersey Special Olympics and the Governor's Council on Physical Fitness.

Congressman Ed Patten, Paul Krebs and other political and boxing personalities were present at the ceremony, and were the world middleweight and lightweight champions and other boxers.

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We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately the psychopathy of substance abuse and addiction always gets worse while it is ignored.

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Help us to help our impaired colleagues.

LETTERS FOR THE INFORMATION OF OUR READERS

Epidemiologic Cancer Studies

September, 1980

Dear Dr. Baker:

As you know, the New Jersey State Department of Health has been engaged in epidemiologic studies of cancer in New Jersey. These studies have been of two types: one type involving the descriptive epidemiology of cancer in the State, and the other involving retrospective case-control studies of cancers of several anatomic sites. Many of the members of the Medical Society of New Jersey have participated in these latter studies by providing information to us on specific patients.

The descriptive epidemiologic studies have examined cancer mortality in New Jersey for a large number of anatomic sites, considering both time trends and the geographic distribution of each disease. We are now compiling an atlas of cancer mortality in the State which should be available for distribution in the fall. In addition, we are tabulating the data for the first year of the New Jersey Cancer Incidence Registry, and plan to release a report of the 1979 data by the end of the year. We now are conducting a quality control evaluation of registry data, which is designed to determine the completeness and accuracy of reporting to the Registry. This will be done by reviewing pathology logs and hospital records.

We have completed the interview phase of case-control studies of two anatomic sites, bladder and liver. The analyses of the data for these studies are now in process. A large portion of the bladder cancer study interviews was included in a National Cancer Institute study, the National Survey of Environment and Health. This study was conducted in ten areas of the country, including New Jersey, and had as one of its primary objectives the study of the relationship of saccharin and bladder cancer. One of the requirements of the study was that the patients themselves be interviewed, not next of kin. Thus, rapid reporting of bladder cancer was necessary.

We are now planning a retrospective case-control study of lung cancer. Our descriptive epidemiologic studies have identified areas in New Jersey with especially high white male lung cancer mortality rates. Concentrations of municipalities with high mortality rates were observed in Camden and Ocean Counties. A cluster also occurred in the municipalities surrounding Newark Bay, communities bordering Raritan Bay, and in the Trenton area. There were no concentrations of municipalities with significantly high white female mortality rates for lung cancer, nor was there any general pattern of clustering of high rates for either sex in all other racial groups. This different pattern between race-sex groups suggests that occupational factors may be influencing the high rates.

The study will involve male lung cancer patients in these specific areas. The study population will include all males who were diagnosed with primary carcinoma of the trachea, bronchus, lung, or pleura (histologically confirmed) during the one-year period September 1, 1980 to August 31, 1981, and who were residents of the geographic areas in which we identified clusters of high mortality rates.

The study will be conducted by personal interview of the lung cancer patients. The questionnaire will include a detailed smoking history and a complete residential and occupational history. There will be brief sections on diet, particularly related to Vitamin A, and on exposure to radiation. The questions are rather detailed, and, as I am sure you realize, the best and most accurate information only can come from the patient himself. For this reason, we need to include in our study as many incident cases as possible, rather than rely on information collected from a family member.

Under regulations developed for the State Cancer Registry, information on all incident cancer cases must be reported to the Registry by the hospital in which the diagnosis was made within six months of the date of diagnosis or within three months of the date of hospital discharge, whichever is sooner. However, because of the relatively poor survival rate of lung cancer patients, a delay of three to six months may mean some patients will have died before they can be approached for an interview. There may be different characteristics between those dying soon after diagnosis and those surviving over six months. We would like to minimize this bias by interviewing cases as soon after diagnosis as possible. We are asking pathologists to send us, as soon as possible after diagnosis, a copy of the pathology report of each male lung cancer case who is a resident of the specified geographic area.

We will be contacting members of your Society concerning our study. In all situations where we interview living patients, we first contact the patient's physician to determine that an interview is not medically contraindicated. At that time, we also will confirm the patient's address and date of diagnosis and obtain information on any other cancer diagnosis which the patient may have had.

Epidemiologic studies of cancer are of considerable importance. I hope our mutual efforts in the upcoming lung cancer study will be beneficial and contribute to the understanding of lung cancer risk factors and ultimately to greater control of the disease.

If you would like to discuss our upcoming study in more detail, please feel free to contact Dr. Ronald Altman, Assistant Commissioner for the Division of Epidemiology and Disease Control, at 609-292-4046.

(signed) Joanne E. Finley, M.D.
State Commissioner of Health

LETTERS TO THE JOURNAL

Cerebral Concussion

September 22, 1980

Dear Doctor Krosnick:

In the September 1980 issue of *The Journal* of the Medical Society of New Jersey, Vol. 77, No. 10, pp. 637-641, I recently read an article by Drs. Maio and Dwyer who surveyed 457 patients in the Passaic Valley area, admitted with the diagnosis of cerebral concussion to various hospitals, and this was done under PSRO auspices. The study was carried prospectively and retrospectively. I cannot help but comment about a paper which I do feel has very definite value to physicians handling cases of cerebral concussion.

Throughout my lifetime career in neurological surgery I always have insisted that cerebral concussion be treated with an overnight stay in a hospital. There are those who would contest this judgment, however, I feel very definitely that this is advisable for all of us to adhere to. I personally feel that these cases should be in the hands of neurosurgeons or of neurologists, but one can understand cases being admitted to a pediatric service, or certainly cases admitted to a surgeon in charge of a traumatic case in which many systems may be involved. However, the points that have been stressed in this article—that a neurological consultation be carried out by a medical or surgical neurologist and a set of skull x-rays be taken—are extremely important. Certainly, neurologists, whether they be medical or surgical, readily will be consulted about the post-traumatic state which may ensue in a certain number of these cases, and which frequently is contested by liability and legal problems at some future date. I am also certain that the majority of physicians know that a temporary period of unconsciousness can represent the early phases of an impending extradural hemorrhage.

Certainly PSRO, in this particular instance, has represented its great value, and I fully agree with the authors' conclusions.

(signed) Robert G. Fisher, M.D.

Subsidization of HMOs

October 7, 1980

Dear Doctor Krosnick:

At the last House of Delegates meeting a resolution was passed decrying the subsidization of HMOs by Federal funding since it was considered to be a fostering of unfair competition.

The reasoning behind this resolution is not clear to me for several reasons. Firstly, we have, as physicians, been subsidizing Blue Shield for almost 50 years by accepting less than our usual fees for treatment of plan members. This puts us in competition with the physicians who are not Blue Shield members. Secondly, all Federal subsidies of HMOs must be paid back with interest. We get no such paybacks from Blue Shield when we subsidize them. It is true that we can bill the patient for the difference if they are in the proper income bracket. Then it is the patient who is subsidizing Blue Shield, since he is paying an insurance premium and the add-on tax to the physician.

Thirdly, in all other insurance plans there is a 20 percent or more deductible, which is a form of subsidization that is paid ultimately by either the patient or the physician, depending upon the circumstances in each individual case.

Therefore, with any form of insurance subsidization in one form or another is a way of life, with either the patient or the physician or both acting as subsidizers. So, why is the HMO subsidy more pernicious and abhorrent than any of the others?

The physician always has been the one who was more interested in his patient's welfare and ultimate return to good health than in exacting the last penny of his fee from the patient when he did not have it. Therefore, there is no valid reason to oppose one plan of many that are subsidized by either the patients or the physicians. All the plans have subsidies of one kind or another, each with its own advantages and disadvantages and effects on competition. We should either support all, or none!

Arthur Bernstein, M.D.

Bradley and HMO

October 10, 1980

Dear Sir:

Senator Bradley recently has written a very provocative article in this *Journal* on Health Care which bears careful reading and analysis.[1]

From my point of view, I believe it contains certain phrases which have been so frequently repeated that they have assumed a validity which is not justified.

Among these phrases is that HMOs tend to improve health "through an emphasis on preventative services" and that they "provide health education which encourages their members to take greater individual responsibility for their own health."

I take this to imply that Senator Bradley assumes that the traditional independent physician does not emphasize preventative services, nor does he encourage patients to take responsibility for their own health as does the HMO health care provider.

I would respectfully request that Senator Bradley detail specifically in what areas HMO's have been demonstrated to improve health care through preventative services and in what areas their members have been shown to take greater individual responsibility for their own health through health education provided by the HMO health providers.

In other words has the Senator from New Jersey merely transmitted nice sounding phrases from Madison Avenue which would be disallowed by the Federal Trade Commission as an unverified advertisement?

To my knowledge, such claims have been neither claimed nor have they been demonstrated by the most ardent HMO enthusiasts. However, in this particular instance, Senator Bradley's influence upon Federal Legislation regarding health care makes his opinions particularly important. Consequently, should these assumptions be in fact unsupported, so also might he temper accord-

[1]Bradley B: Health care: Quality and cost. *J Med Soc NJ* 77:604-605, (Aug) 1980.

ingly his legislative actions.

As Senator Bradley proceeds to analyze his efforts to lower health costs by promoting the HMO system to the Medicare population, he assumes that the HMO provides a "more efficient health care delivery system." Again, this phrase has been repeated so often that it actually sounds meaningful. I would again ask Senator Bradley to be specific in his definition of what is meant by "efficient" as related to health care. I would also request that he let us know what factors enter into his equation that measures "efficiency" in health services in order to permit him to make this statement so definitively.

Senator Bradley also points out that those savings which have been effected by the HMOs were as a result of reduced hospital admissions rates.

On this basis, and projecting Senator Bradley's data, if all patients were subscribers to the HMO type health delivery system the hospital admission rate would be expected to drop an average of 40 percent ("by 30 to 50 percent"). Since the average hospital stay is about the same for the HMO subscriber and traditional patients,[2] this would reduce hospital occupancy by a like amount. Consequently, it would leave us a choice of either running our hospitals an average of 60 percent of their current occupancy or to close 40 percent of our hospitals and allow the remaining hospitals to maintain their current occupancy level. The Senator believes that these excessive hospital admissions can be corrected by better out-patient services, second opinions and other "HMO practices." He also assumes that they are a result of the "wasteful" hospital admission practices of physicians who treat patients in the traditional fashion.

Why, then, does he not propose the immediate closure of 40 percent of our hospitals and thereby force a more "efficient" use of all our out-patient care. This would be a reasonable course of action he might be expected to pursue, if he truly believed in the consequences of his assumptions. This he has not done, perhaps because he knows it is not politically palatable and because of the medical probelms this would create.

Such an action automatically would create a priority system for hospital admissions which would allow only those patients most critically ill to be admitted to the restricted available hospital facilities. All of this would automatically lead to the elimination of current "wasteful hospital admissions" and bring about hospital savings, the only area in which the HMOs have been shown to be effective.

In this way, according to Senator Bradley's analysis, millions of dollars would be saved by *not* imposing the HMO system of regulated health care upon the citizens and medical profession of the United Sates. Such a program would be consistent with the Senator's position.

(signed) Albert Minzter, M.D.

[2]Hospital utilization, in *Health Maintenance Organizations.* Chicago, AMA Council on Medical Services, 1980, page 112.

Physicians and the Nuclear Holocaust

October 17, 1980

Dear Doctor Krosnick:

The editorial in the October 1980 issue of *The Journal* (77:710-711), "Physicians and the Nuclear Holocaust" and the accompanying "open letter" to President Carter and Chairman Brezhnev impressed me as being very important and very timely (especially now, in view of the war in the Middle East). The "Physicians for Social Responsibility" are to be congratulated and commended for what they have done, and presumably will continue to do, in extending clear warnings to all men and nations as to the inconceivable agony and horror that nuclear warfare would bring—and so quickly, at the press of a button—"like the pangs of distress upon a pregnant woman." There would not be the joys that follow delivery; nothing to love, to nurture and to cherish.

The poor response of the two world leaders certainly leaves one with a paucity of hope, if any at all. But does this mean that the outlook is totally black, without light and without any hope? Will the earth really end up a burned-out cinder? Many have thought so, either by nuclear holocaust or cosmic accident. Friends, colleagues, take heart. Yes, there is hope, and much more: absolute assurance!

I'm sure that for most of you such a statement is more than a little hard to swallow. A quotation of Sir William Osler's in this same issue of *The Journal* (p. 717) says, in part, "In no profession does culture count for so much as in medicine." But some of us have experienced and been slightly aghast at its lack in an occasional colleague, even a highly skilled surgeon, unable to write a simple English sentence well.

So it is this *culture* that can well afford to be broadened among us, and it should include a careful study and understanding of the *Holy Bible.* Men of outstanding culture and ability have done that for countless generations and were very much wiser for having done so! They even have acquired what the apostle Paul calls "the peace of God that excels all thought." How badly this is needed in our world right now!

Yes, we can have hope in the midst of world panic and pandemonium. The almighty creator of heaven and earth is well aware of what goes on on our planet. He even foresaw it and prepared for it thousands of years ago. So, we can all draw comfort from the scriptures. But first, how reliable are they? Two thousand years ago the wisest man who ever lived said, "the scripture cannot be nullified" (John 10:35) and "in order that the scripture may be fulfilled" (John 13:18), and also "All this has taken place for the scriptures of the prophets to be fulfilled" (Matthew 26:56).

Here are a few that will help to set our minds at ease:

1. "the true God, the Former of the earth and Maker of it, He, the one who firmly established it, who did not create it *simply for nothing,* who formed it even to be inhabited" (Isaiah 45:18).

2. "The righteous themselves will possess the earth, and they will reside *forever* upon it" (Psalm 37:29).

3. "He has founded the earth upon its established places; it will not be made to totter to time indefinite, or forever." (Psalm 104:5).

4. "A generation is going and a generation is coming; but the earth is standing even to time indefinite." (Ecclesiastes 1:4).

5. "the nations became wrathful, and your own wrath came, and the appointed time for the dead to be judged, and to give their reward to your slaves the prophets and to the holy ones and to bring to ruin those ruining the earth." (Revelation 11:18).

The Journal editorial uses the expression "apocalypse" twice in one of its last paragraphs. My dictionary, under "apocalypse," uses this expression: "The expectation of an imminent *cosmic* cataclysm in which God destroys the ruling powers of evil and raises the righteous to life in a messianic kingdom." Actually "apocalypse" is taken from the Greek word meaning "revelation." The cosmic cataclysm brought

by God is more generally spoken of as Armageddon or Har-Mageddon. So what we are talking about is not a last totally obliterating nuclear war among nations, but God's war against all wicked mankind and wicked angels. The dictionary definition agrees generally with that of the most careful and erudite of *Bible* scholars.

In view of the foregoing discussion and scriptures, there is just no chance of the earth and all life upon it being destroyed by man. Rather it is to be converted into a total paradise (what the Almighty had in mind from the beginning). So, do we have anything to fear? Indeed we do. Remember, the flood in Noah's day, Sodom and Gomorrah and Pharoah of Egypt and the cataclysms upon them. All had survivors.

So will there be very shortly, at the end of this present-day wicked world system.

For two thousand years millions have prayed, "Let your will be done on earth as it is in heaven." Those who really do it are the ones who are the meek who will possess the earth. But how can one be sure he is doing God's will if he has not made a careful study of His Word and instructions? We will not be "left in the lurch" if we take such action. Jesus said if anyone even so much as gave one of his followers "a cup of cold water to drink because he is a disciple" (one able to recognize a true disciple of Christ) he would not lose his reward. God's promises never fail of fulfillment.

May Jehovah, Creator and Sustainer of all things, bless as many of us as He chooses according to our faith, our trust in him.

(signed) F. Dean Roylance, M.D.

October 20, 1980

Dear Doctor Krosnick:

I was very glad to see your editorial, "Physicians and the Nuclear Holocaust," in the October issue of the *Journal* (77:710-711). At the end of the editorial, you make three suggestions for actions that physicians might take. The actions you suggest seem small and pale against the enormity of the nuclear problem.

The best thing we could do as a medical society would be to endorse the open letter signed by Physicians for Social Responsibility. If the AMA could endorse that letter, other national organizations might do so as well.

(Signed) Reed C. Perron, M.D.

October 20, 1980

Dear Dr. Krosnick:

Thank you very much for your thoughtfulness in sending me a copy of the October edition of *The Journal.*

I read with interest your editorial on the nuclear holocaust (77:710-711). While we have taken steps in recent years to upgrade our civil defense capabilities, they are still lacking.

Perhaps when Congress reconvenes in November, the Senate will be able to readdress the SALT II treaties. A rational discussion of arms limitation between the two super-powers is the best defense against nuclear war. When nuclear weapons are at stake there can be no limited encounters.

Again, I do appreciate hearing from you on this important issue.

(Signed) William J. Hughes
Congressman, 2nd District, NJ

October 21, 1980

Dear Dr. Krosnick:

Your editorial on "Physicians and the Nuclear Holocaust" (*J Med Soc NJ* 77:710-711) was marvelous, and I am proud that you wrote it. I happen to be a member of PSR, and would be pleased to be more active should the occasion arise.

Congratulations.

(Signed) Victor Parsonnet, M.D.

October 30, 1980

Dear Dr. Krosnick:

Thank you for your recent communication containing a copy of the magazine, *The Journal* of the Medical Society of New Jersey. I appreciate your taking the time to share this material with me.

Clearly the major threat to the future existence of mankind is the use of nuclear weapons. Already there are several nations capable of using these weapons and with their possible spread or proliferation, the odds on their use increase dramatically. There must be a concerted effort on the part of all world governments to check this possibility and come to an agreement on the future production, testing and dismantlement of nuclear weapons. As mentioned in your article, there can be no winners even in a limited nuclear exchange.

I have and will continue to work with my colleagues in the House and Senate to bring about the objectives cited in the letter contained in your article. Please feel free to contact me in the future should the need arise.

(signed) Frank Thompson, Jr.
Congressman, 4th District, NJ

Informative and Provocative

October 3, 1980

Dear Sir:

The article on anorexia nervosa by Dr. Mintz (77:333-339, (May) 1980) was a splendid example of clinical observation and reporting. One question: How well and how quickly does the amenorrhea respond to psychotherapy?

Let me take this opportunity to congratulate you on the generally high quality of *The Journal.* Our Jerusalem Association for the Advancement of Family Practice has a weekly Journal Club, of which your long-term Society member, Dr. Milton Gordon, is a member, and he regularly circulates your *Journal* which we always find informative and provocative.

(signed) Mortimer S. Rayman, M.D.
Jerusalem, Israel

215th Annual Meeting
Medical Society of New Jersey
May 15-19, 1981

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PROGRAM:
PEDIATRIC UPDATE—1981

SPONSOR:
Department of Pediatrics
Long Island Jewish-Hillside Medical Center
New Hyde Park, N.Y.

LOCATION:
Marbella, Spain, on the Costa del Sol

DATES:
February 28-March 8, 1981

CREDITS:
20 credits AMA, Category I
20 credits LCCME

FACULTY:
International faculty includes:
Professor Victor Dubowitz, London, England
Professor John O. Forfar, Edinburgh, Scotland
Professor Walter H. Hitzig, Zurich, Switzerland
Professor Ettore Rossi, Bern, Zwitzerland
Professor R. Zetterstrom, Stockholm, Sweden

TUITION:
$185; $315 MAP (full American breakfast and dinner)

INFORMATION:
Continuing Education Coordinator
Long Island Jewish-Hillside Medical Center
New Hyde Park, N.Y. 11042
(212) 470-2114

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Jan.

14 **Anesthesia for Diagnostic Studies**
8-9:30 p.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

20 **Dinner Meeting**
6 p.m.—Ramada Inn, Clark
(NJ State Society of Anesthesiologists and AMNJ)

Feb.

11 **Anesthesia for Various Myopathies**
8-9:30 p.m.—West Jersey Hospital, Voorhees
(Department of Anesthesia, West Jersey Hospital)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Jan.

1 **Medical Grand Rounds**
9:30-11 a.m.—Newark Beth Israel Medical Center
(Endocrinology Section of AMNJ)

2 **Renal Conferences in Nephrology**
16 2-3:15 p.m.—College Hospital, Newark
(Nephrology Society of NJ and AMNJ)

2 **Medical Grand Rounds**
11:30 a.m.-1 p.m.—College Hospital, Newark
(Endocrinology Section of AMNJ)

5-6 **Advanced Cardiac Life Support Course**
28- 9-5 p.m.—NJ Medical School, Newark
29 *(CMDNJ and AMNJ)*

6 **Thyroid Diseases**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

7 **Diabetes Mellitus**
1-2:30 p.m.—VA Medical, Lyons
(VA Medical Center and AMNJ)

7 **Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(Endocrinology Section of AMNJ)

7 **Coronary Artery Disease Workshop**
9-11 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

7 **Endocrine Conferences**
14 3:30-5 p.m.—Rotates between, Newark
21 Beth Israel Medical Center, College
28 Hospital, Newark, and VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

7 **Endoscopic Retrograde Cholangio-Pancreatography**
1:30-2:30 p.m.—Rutgers Community Health Plan—57 U.S. Highway 1 & Rt. 18, New Brunswick
(Rutgers Community Health Plan and AMNJ)

7 **Medical Grand Rounds**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(AMNJ)

7 **Medical Lecture Series**
14 1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

7 **Internal Medicine and Therapeutics**
14 9-11 a.m.—Roosevelt Hospital, Menlo
21 Park
28 *(Middlesex General Hospital and AMNJ)*

8 **Recurrent Ventricular Tachycardia**
8-9 p.m.—Burlington County Memorial Hospital, Mount Holly
(Burlington County Medical Society and AMNJ)

8 **Neuro-Ophthalmology**
4-5:30 p.m.—NJ Medical School, Newark
(CMDNJ)

8 **Immunology '81**
15 4-6 p.m.—Copewood Street, Camden
22 *(Institute for Medical Research and*
29 *AMNJ)*

13 **Helping Your Patient with Cosmetics**
8-10 p.m.—Schering Corporation, Kenilworth
(NJ Dermatological Society and AMNJ)

13 **Athletic Injuries**
27 **Use and Misuse of Oxygen Therapy**
12 noon-2 p.m.—West Jersey Hospital, Camden
(West Jersey Hospital)

14 **Adrenal Diseases**
11:30 a.m.—Rahway Hospital
(AMNJ)

14 **Hypertrophic Sub-Aortic Stenosis**
2 p.m.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)

14 **Lesions of the Oral Cavity**
21 **Respiratory Failure**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

14 **Cardiology Conferences**
28 3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick
(CMDNJ, Somerset County Medical Association and AMNJ)

14 **Combinations of Antibiotics and Infections**
21 **Diabetes**
1-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

14 **Middle Ear Disease and Tympanometry**
8 a.m.-6 p.m.—499 Broad Street, Shrewsbury
(Otologic Education, Inc., and AMNJ)

15 **Newer Drugs in Hypertension and Mechanisms of Diuretic Actions**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

15- **Postgraduate Allergy Workshops**
18 Winter Conference-Pocono Manor Inn Pocono Manor, PA
(Holy Name Hospital and AMNJ)

16 **Hepatitis**
12 noon-Freehold Area Hospital
(AMNJ)

19 **Coagulation Defects**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(West Hudson and AMNJ)

20 **Common Geriatric Diseases**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

20 **Idiopathic Thrombocytopenic Purpura**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

21 **Adult Respiratory Distress Syndrome**
11:30 a.m.1- p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

21 **Dermatological Conference**
6 p.m.—Rutgers Community Health Plan Bldg. 57 U.S. Highway 1 & Rt. 18, New Brunswick
(Rutgers Medical School)

21 **Hypokalemia and Ventricular Ectopic Activity**
1:30-2:30 p.m.—Rutgers Community Health Plan, 57 U.S. Highway 1 & Rt. 18, New Brunswick
(Rutgers Community Health Plan and AMNJ)

21 **Common Sexual Dysfunctions**
9-11 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

27 **Topic to be announced**
7:30-9 p.m.—Coachman Inn, Cranford
(New Jersey Blood Club and AMNJ)

28 **Zollinger-Ellison Syndrome**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

Feb.

3 **Colitis**

11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

4 **Topic to be announced**
6:30 p.m.—The Manor, West Orange
(AMNJ)

4 **Abdominal Ultrasonography**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

4 **Endocrine Factors in Renal Disease**
6 p.m.—Holiday Inn, Evergreen Place, East Orange
(The Society of Nephrology and AMNJ)

4 **Evaluation of the Thyroid Nodule**
1:30-2:30—Rutgers Community Health Plan, 57 U.S. Highway & Rt. 18, New Brunswick
(Rutgers Community Health Plan and AMNJ)

4 **Malignancies of the Upper Gastrointestinal Tract**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

4 **Thyroid Diseases**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

4 **Treatment of Alcoholism**
9-11 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

4 **Fluid and Electrolyte Imbalance**
1 p.m.—Christ Hospital, Jersey City
(AMNJ)

4 **Transfusion Therapy**
11:30 a.m.—Rahway Hospital
(AMNJ)

4 **Monthly Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(AMNJ)

4 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(AMNJ)

4 **Exercise Electrocardiography**
25 **Chronic Hepatitis**
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(Joint Education Committee of Dover General, Riverside, and St. Clare's Hospitals and AMNJ)

4 **Internal Medicine and Therapeutics**
11 9-11 a.m.—Roosevelt Hospital, Menlo
18 Park
25 *(Middlesex General Hospital and AMNJ)*

4 **Fluid and Electrolyte Imbalance**
11 **Medical Lecture Series**
18 1-3 p.m.—Christ Hospital, Jersey City
25 *(Christ Hospital and AMNJ)*

4 **Endocrine Conferences**
11 3:30-5 p.m.—Rotates between Newark
18 Beth Israel Medical Center, College
25 Hospital Newark, and VA Medical Center, East Orange *(AMNJ)*

4 **Medical Lecture Series**
11 1-2:30 p.m.—VA Medical Center, Lyons
18 *(VA Medical Center and AMNJ)*
25

5 **Medical Grand Rounds**
9:30 a.m.-11 a.m.—Newark Beth Israel Medical Center
(AMNJ)

5 **Joint Neurosurgery ENT Conference**
4-5:30 p.m.—NJ Medical School, Newark
(CMDNJ)

5 **Immunology '81**
12 4-6 p.m.—Institute for Medical Research Copewood St., Camden
(Institute for Medical Research and AMNJ)

6 **Medical Grand Rounds**
11:30-1 p.m.—College Hospital, Newark
(AMNJ)

6 **Renal Conference in Nephrology**
20 2-3:15 p.m.—College Hospital, Newark
(Nephrology Society of NJ and AMNJ)

10 **Pigmentation Problems**
8 p.m.—Schering Corporation, Kenilworth
(New Jersey Dermatological Society and AMNJ)

10 **The Patient with Joint Symptoms**
24 **Diabetes Mellitus**
12 noon-2 p.m.—West Jersey Hospital, Camden
(West Jersey Hospital)

11 **Chronic Renal Failure in Geriatric Patients**
2 p.m.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)

11 **Cardiology Conferences**
25 3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick
(CMDNJ, Somerset County Heart Association and AMNJ)

12 **Topic to be announced**
7:30-9:30 p.m.—Overlook Hospital, Summit
(NJ Institute of Ultrasound in Medicine and AMNJ)

17 **Hypertension**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)

17 **Newer Concepts in Hepatitis**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

18 **Dermatological Conference**
6-8 p.m.—Rutgers Community Health Plan, 57 U.S Highway & Rt. 18, New Brunswick
(CMDNJ and AMNJ)

18 **Asthma Fatalities**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

18 **Endocrinology/Metabolism: Thyroid Diseases**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(Columbus Hospital and AMNJ)

18 **Kidney Stones**
1:30-2:30 p.m.—Rutgers Community Health Plan, 57 U.S Highway 1 & Rt. 18, New Brunswick
(Rutgers Community Health Plan and AMNJ)

20 **Leukemia**
12 noon-Freehold Area Hospital
(AMNJ)

25- **Advanced Cardiac Life Support Course**
26 9 a.m.-5 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)

NEUROLOGY/PSYCHIATRY

Jan.

3 **Cancer Related Depression**

16 **The Private Practice of Family Therapy**
17 **Cerebral Metabolism**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation)

5 **Psychiatric Complications in a Juvenile Diabetic**
8-10 p.m.—4 Garden Place, Nutley
(Essex Psychiatric Doctors Seminars and AMNJ)

5 **Evaluation of Diseases of the Autonomic**
12 **Nervous System**
19 11:30 a.m.-12:30 p.m.—Bergen Pines
26 County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

6 **Psychiatric Case Conference**
13 7:30-9:30 a.m.—Trenton Psychiatric
20 Hospital
27 *(Trenton Psychiatric Hospital and AMNJ)*

7 **Ongoing Child Psychiatry Case**
14 **Conference and Lecture**
21 8:30-10:30 a.m.—Trenton Psychiatric
28 Hospital
(Trenton Psychiatric Hospital and AMNJ)

7 **Family Therapy**
21 **Motor Control and Recovery of Motor Functions**
4:15-5:15 p.m.—Kessler Institute for Rehabilitation, West Orange
(Kessler Institute and AMNJ)

8 **Case Presentation**
22 **Emergency Use of Psychotropic Drugs**
29 **Psychopharmacology**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

8 **Sleep Disorders**
24 **Case Reviews**
31 **Family Therapy-Case Presentation**
12 noon-1:30 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation)

10 **Psychotherapy of Schizophrenia**
12 noon-2 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation)

14 **The Psychiatric Treatment of Susan**
8-10 p.m.—Ramada Inn, Valley Rd., Clark
(New Jersey Council of Child and Adolescent Psychiatry and AMNJ)

14 **Psychohistory**
21 **Family Therapy**
28 **Behavioral Therapy of Borderlines**
1-3 p.m.—Ancora Psychiatric Hospital
(Ancora Psychiatric Hospital and AMNJ)

21 **Affective Illnesses**
1:30-3 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)

21 **Psychiatric Disorders in Drug Abusers**
1:30 p.m.—Trenton Psychiatric Hospital
(AMNJ)

22 **A Psychoanalytic Note on Richard Strauss**
8:30-11 p.m.—Hackensack Hospital
(NJ Psychoanalytic Society and AMNJ)

Feb.

2 **Ugly Duckling**
8-10 p.m.—39 Crescent Ave., Passaic
(Essex Psychiatric Seminars and AMNJ)

2 **Neuroscience Conferences**
9 11:30 a.m.-12:30 p.m.—Bergen Pines
16 County Hospital, Paramus
23 *(Bergen Pines County Hospital and AMNJ)*

3 **Psychiatric Case Conferences**
10 7:30-9:30 a.m.—Trenton Psychiatric
17 Hospital
24 *(Trenton Psychiatric Hospital and AMNJ)*

4 **Treatment of Speaking Anxiety**
18 **The Psychiatric Emergency**
25 **New Advances in Psychopharmacology**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

4 **Child Psychiatry Case Conference and**
11 **Lecture**
18 8:30-10:30 a.m.—Trenton Psychiatric
25 Hospital
(Trenton Psychiatric Hospital and AMNJ)

5 **Psychopharmacology and the Geriatric Patient**
12 **Case Presentation**
19 **Brief Psychotherapy Techniques**
26 **Brief Psychotherapy Techniques**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

7 **Teaching of Family Therapy**
14 **Practical Aspects of Family Therapy**
28 **Research in Family Therapy**
12-1:30 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

11 **Parkinson's Disease**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

12 **The Latency Period in Girls**
8:30-11 p.m.—St. Barnabas Hospital, Livingston
(NJ Psychoanalytic Society and AMNJ)

18 **Lithium: Other Uses and Causes**
1:30 p.m.—Trenton Psychiatric Hospital
(AMNJ)

19 **Family Therapy for Psychosomatic Disorders**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

20 **Hypnosis**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

OBSTETRICS/GYNECOLOGY

Jan.

7 **Distinguished Lectures in Obstetrics/Gynecology**
6-7 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)

14 **Menopause**
8-9 a.m.—Garden State Community Hospital, Marlton
(Garden State Community Hospital and AMNJ)

22 **Bladder and Bowel Repair During Gynecologic Surgery**
4-5:30 p.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

28 **Office Gynecology**
1-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

Feb.

4 **Distinguished Lectures in Obstetrics/Gynecology**
6-7 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)

7 **Genetic Counseling—Who Needs It?**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

26 **Ovarian Carcinoma**
4-5:30 p.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

PEDIATRICS

Jan.

16 **Endocrinology**
7:45-9:15 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

19 **Neonatal Seizures**
12-1 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital and AMNJ)

Feb.

5 **Hypertension in Children**
9 a.m.—Freehold Area Hospital
(AMNJ)

20 **Microscopic Hematuria in Children**
7:45-9:15 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

RADIOLOGY

Jan.

14 **Case Presentations**
7:45-10:15 p.m.—Morristown Memorial Hospital
(Radiological Society of NJ and AMNJ)

14 **Radiology-Nuclear Medicine**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(AMNJ)

15 **Pediatric Radiology**
8 p.m.—Hospital Center at Orange
(Radiological Society of NJ and AMNJ)

15 **The Esophagus in the Newborn and Infant**
8 p.m.—Hospital Center at Orange
(Radiological Society of NJ and AMNJ)

21 **Dinner Meeting**
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

22 **Visiting Professorship Program**
1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston
(St. Barnabas Medical Center and AMNJ)

29 **Neuro-Radiology Conference**
4-5:30 p.m.—NJ Medical School, Newark
(CMDNJ)

Feb.

11 **Radiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital
(Radiological Society of NJ)

19 **Topic to be announced**
8 p.m.—Hospital Center at Orange
(Radiological Society of NJ and AMNJ)

25 **Radiation Therapy of Cancer of the Uterus**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(Columbus Hospital and AMNJ)

26 **Visiting Professorship Program**
1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston
(St. Barnabas Medical Center)

GENERAL SURGERY

Jan.

2 **Tumor Conference**
16 12 noon-1 p.m.—Elizabeth General Hospital
(Elizabeth General Hospital and AMNJ)

6 **Tumor Conference**
13 12 noon-1 p.m.—Morristown Memorial
20 Hospital
27 *(Morristown Memorial Hospital and AMNJ)*

6 **Gallstone Pancreatitis**
5-6 p.m.—Rutgers Medical School, Piscataway
(CMDNJ and AMNJ)

7 **Orthopedic Problems**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(AMNJ)

14 **Tumors of the Biliary Tract**
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(Joint Education Committee of Dover General, Riverside & St. Clare's Hospitals, Denville and AMNJ)

15 **Carotid Artery Surgery**
7:30-9 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

21 **Surgery for Congenital Heart Disease**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(Columbus Hospital and AMNJ)

24 **Thrombo-Embolic Complications Following Surgery**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

Feb.

3 **Soft Tissue Sarcomas**
24 **Radionuclides in Surgical Diagnosis**
5-6 p.m.—Rutgers Medical School, Piscataway
(CMDNJ and AMNJ)

3 **Tumor Conferences**
10 12 noon—Morristown Memorial
17 Hospital
24 *(Morristown Memorial Hospital and AMNJ)*

18 **Deep Vein Thromboses**
7:30-9 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastic, and Vascular Surgery)

Jan.

7 **Orthopedic Problems**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)

8 **Neuroophthalmology**
15 **Neurosurgery Conference**
22 **Joint Neurosurgery Orthopedic Conference**
29 **Neuroradiology Conference**
4-5:30 p.m.—NJ Medical School, Newark
(CMDNJ)

10 **Reconstructive Surgery for Rheumatoid and Degenerative Arthritis**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

27 **Advances in Vitreo-Retinal Surgery**
8-10 p.m.—Englewood Club, 115 East Palisade Ave., Englewood
(Englewood Surgical Society and AMNJ)

Feb.

5 **Joint Neurosurgery ENT Conference**

12 **Neurosurgery-Plastic Surgery Conference**

19 **Neurosurgery Orthopedic Conference**

26 **Neurosurgery Conference**
4-5:30 p.m.—NJ Medical School, Newark
(CMDNJ)

24 **Silicone in Hand Surgery**
8-10 p.m.—Englewood Club, 115 East Palisade Ave., Englewood
(Englewood Surgical Society and AMNJ)

MISCELLANEOUS

Jan.

7 **Prostaglandins**
1 p.m.—Christ Hospital, Jersey City
(AMNJ)

Feb.

4 **Legislation and the Handicapped**
4:15-5:15 p.m.—Kessler Institute for Rehabilitation, West Orange
(Kessler Institute and AMNJ)

OBITUARIES

Dr. Joseph A. Connolly

Joseph A. Connolly, M.D., of Plainfield, a member of our Union County component, died on September 24. A native of New Jersey, born in 1922, Dr. Connolly was graduated from Georgetown University Medical School, class of 1946, and pursued graduate work in obstetrics and gynecology, becoming board certified in that field. He was a Fellow of the American College of Obstetricians and Gynecologists and was senior attending obstetrician at Muhlenberg Hospital in Plainfield. During World War II Dr. Connolly served with the medical department of the United States Navy.

Dr. Ferdinand J. DeCesare

One of Union County's senior emeritus members, Ferdinand J. DeCesare, M.D., died on October 20 in Paul Kimball Hospital, Lakewood after a long illness. A native of New York City, Dr. DeCesare was graduated from Tulane University Medical School in 1925 and took graduate work in gynecologic surgery at Cook County Postgraduate Hospital in Chicago. He came to New Jersey in 1925 and established a practice in Roselle Park which he maintained until retirement to Lakewood in 1972. He had been on the staffs of St. Barnabas Medical Center in Livingston, and St. Elizabeth, Elizabeth General and Alexian Brothers Hospitals In Elizabeth. He was a Fellow of the International Academy of Proctology and of the American Academy of Family Physicians. In 1975, Dr. DeCesare was a recipient of MSNJ's Golden Merit award, indicating fifty years of medical practice. He had been active in his community and served as chief medical officer of civilian defense during World War II. He also was school physician for fifteen years and police and fire surgeon for twenty years for the town of Elizabeth. Dr. DeCesare was 80 years old at the time of his death.

Dr. Ferdinand K. Engelhart

One of Trenton's well-known gynecologists, Ferdinand K. Engelhart, M.D. died at his home on October 12. Born in Trenton in 1910, Dr. Engelhart was a graduate of Temple University School of Medicine, class of 1934, and pursued a residency in obstetrics and gynecology at the Graduate School of Medicine of the University of Pennsylvania, becoming board certified in that specialty. He was a Fellow of the American College of Surgeons and of the American College of Obstetricians and Gynecologists, and had been attending gynecologist at the Mercer Medical Center in Trenton.

Dr. Hugh E. F. Flood

The former acting director of the Margaret Hague Maternity Hospital, Hugh E. F. Flood, M.D., died on October 20 at Palisades General Hospital, North Bergen. A native of New York City, born in 1918, Dr. Flood was graduated from New York Medical College in 1943 and pursued graduate training in obstetrics and gynecology, becoming board certified in that field. He was a Fellow of the American College of Surgeons and of the American College of Obstetricians and Gynecologists and was on the staff at Margaret Hague and Christ Hospitals in Jersey City. He was a member of the Hudson County Medical Society. During World War II, Dr. Flood served with the department of medicine of the United States Navy.

Dr. Martin Gold

Martin Gold, M.D., a member of our Essex County component, died suddenly on September 27 at Mountainside Hospital in Montclair of a heart ailment. A native of Brooklyn, Dr. Gold was graduated from SUNY College of Medicine, class of 1952, and established a family practice in Montclair. He was a diplomate of the American Board of Family Practice and was an attending physician and associate director of the family practice residency training program at Mountainside Hospital. During World War II Dr. Gold served with the medical department of the AUS. He was only 56 years old at the time of his death.

Dr. Carl G. Hanson

Word just has been received of the death on July 4th at Neurological Institute, Columbia/Presbyterian Medical Center, New York City, of Carl G. Hanson, M.D., of Cranford. A native of

Brunswick, Minnesota, Dr. Hanson was graduated from the University of Minnesota School of Medicine, class of 1933, and took graduate training in pediatrics at New York Postgraduate Hospital and later at Harvard Medical School. He had practiced in Cranford from 1934 until retirement in 1975. He had established the pediatric department at the Rahway Hospital and served later as president of the medical staff. At the Muhlenberg Hospital in Plainfield, he was chief of the department of pediatrics and a member of the hospital's board of governors. Dr. Hanson was president of his county medical society (Union) in 1955 and was a member of the New Jersey Chapter of the American Academy of Pediatrics. He was past trustee of the Union County Heart Association and of the Union County Unit of Retarded Children. He was a prime mover in the establishment of the Union County Mental Hygiene Clinic and in 1960 organized the state's first streptococcal diagnostic study for the prevention of rheumatic fever. Dr. Hanson was 75 years old at the time of his death.

Dr. Emanuel B. Kaplan

One of Bergen County's senior members, Emanuel B. Kaplan, M.D., died suddenly on September 20 at Holy Name Hospital in Teaneck of a heart ailment. A native of Russia, born in 1894, Dr. Kaplan was graduated from Kharkov Imperial University Medical School in 1916. He emigrated to the United States in 1924 and pursued residencies in orthopedic surgery and hand surgery at the Hospital for Joint Diseases in New York. He was board certified in his chosen field and a Fellow of the American College of Surgeons. He had been on the staff at Hackensack Hospital, Holy Name Hospital in Teaneck, St. Joseph's Hospital in Paterson, Pascack Valley Hospital in Westwood, Valley Hospital in Ridgewood, the Hospital for Joint Diseases in New York City, and Lebanon Hospital in the Bronx. He had been a member of the faculty at the College of Physicians and Surgeons of Columbia University as assistant professor of anatomy and of the New Jersey Medical School, CMDNJ, as clinical professor of orthopedic surgery. Dr. Kaplan held membership in numerous scientific and medical societies in the United States and abroad. He was the author of several textbooks on surgery of the hand and other extremities, and published frequently in medical journals on topics of orthopedic surgery, anatomy, and the history of medicine. Previously he had been associate editor of the *Journal of Bone and Joint Surgery* and editor of the *Bulletin* of the Hospital for Joint Diseases in New York City. In 1975 Dr. Kaplan was the recipient of MSNJ's Golden Merit Award indicating 50 years of medical practice.

Dr. Joseph J. LoFaro

One of Bergen County's family practitioners, Joseph J. LoFaro, M.D., formerly of Cliffside Park and Fort Lee, died on September 21 at Columbia-Presbyterian Hospital in New York following a cerebrovascular accident. A native of Tarrytown, New York, born in 1919, Dr. LoFaro was graduated from the University of Messina (Italy) Medical School in 1946 and after two years in military service came to New York City for internship and residencies at Fordham Hospital and New York University Medical School. He had been affiliated with the Englewood Hospital and Holy Name Hospital in Teaneck and was a member of the American Academy of Family Practice. Dr. LoFaro was active in civic affairs and had been medical director of the Board of Health of Fort Lee and a member of the Fort Lee Board of Education.

Dr. Roger D. Lovelace

A member of our Gloucester County component, Roger D. Lovelace, M.D., died at his home on September 25 after a prolonged illness. A native of Philadelphia, born in 1926, Dr. Lovelace was graduated from Jefferson Medical College, class of 1953, and established a family practice in Pitman. He was affilated with the Community Hospital in Elmer, the Underwood Memorial Hospital in Woodbury and the Washington Memorial Hospital in Turnersville. Dr. Lovelace was active in community affairs and served as school physician to the borough of Pitman.

Dr. L. Keith Madison

One of Hudson County's senior members, L. Keith Madison, M.D., of Jersey City, died on August 16 at Pollak Hospital, Jersey City, of a heart ailment. A graduate of Howard University School of Medicine in 1924, Dr. Madison was a family practitioner in Jersey City until retirement in 1975. He was 81 years old at the time of his death. In 1974 he was a recipient of MSNJ's Golden Merit Award indicating fifty years of medical practice.

Dr. Herbert Mahood

On October 21, one of Essex County's senior members, Herbert L. Mahood, M.D., died in Verona, Vermont after a long illness. A native of Iowa, Dr. Mahood was graduated from Columbia University's College of Physicians and Surgeons in 1926 and pursued a career in general surgery in Maplewood. He had been a member of the surgical staff at Orange Memorial Hospital until retirement to Keene, New Hampshire in the early 1970s Dr. Mahood was 83 years old at the time of his death.

Dr. Anthony G. Merendino

On September 18, Anthony G. Merendino, M.D., of Margate, died after a short illness. A native of Atlantic City, Dr. Merendino was graduated from Jefferson Medical College in 1929 and pursued a career in general surgery. He had been affiliated with Atlantic City Hospital and was a Fellow of the American College of Surgeons and of the International College of Surgeons. In more recent years he had practiced general medicine in Margate. During World War II Dr. Merendino served with the medical department of the U.S. Navy. He was 75 years old at the time of his death. Last year Dr. Merendino was a recipient of MSNJ's Golden Merit Award in recognition of 50 years of medical practice.

Dr. Karl E. Morris

Word just has been received of the death on June 8 of Karl Elwood Morris, M.D., formerly of Middletown, New Jersey. A graduate of Temple University Medical School, class of 1935, Dr. Morris had been a general practitioner in Westfield until retirement in 1976.

Dr. Thomas F. Nevins, Jr.

Thomas F. Nevins, Jr., M.D., a member of our Union County component, died on September 29. A native of Brooklyn, born in 1915, Dr. Nevins was graduated from Long Island University College of Medicine in 1941 and pursued a career in industrial medicine and research. He had been affiliated with the Bayway Refinery in Linden for many years. Dr. Nevins was a diplomate of the American Board of Preventive Medicine and a Fellow of the American Public Health Association and of the American College of Preventive Medicine, as well as a member of the Academy of Medicine of New Jersey. He had been affiliated with the Elizabeth General Hospital.

Dr. Clara C. Renner

Notice has been received of the death in Sioux Falls, South Dakota, in March, of Clara C. Renner, M.D., an active participant in the fields of public health and mental health in Mercer and Somerset Counties during the 1940s and 1950s. A native of South Dakota, born in 1885, Dr. Renner was graduated from the University of Iowa School of Medicine in 1910 and worked briefly at a state hospital there before coming to New Jersey where her husband, Daniel S. Renner, M.D., had accepted an appointment as chief physician, later superintendent, of the New Jersey State Village for Epileptics at Skillman, the forerunner of today's New Jersey State Neuropsychiatric Institute. In addition to her activities in the medical field she was secretary of the Somerset County Welfare Board for 23 years and supervisor of the rural health program, and, as the wife of a physician, was an active member of the Woman's Auxiliary of MSNJ, working toward greater cooperation between the Auxiliary and the State Society. In 1960 Dr. Renner received MSNJ's Golden Merit Award indicating fifty years of medical practice.

Dr. Jerome C. Rothgesser

We just have been notified that the former Medical Director of Medical-Surgical Plan of New Jersey, Jerome C. Rothgesser, M.D., died on April 10, 1979 in Clermont, Florida where he had been living since retirement in 1976. Born in New York City in 1911, Dr. Rothgesser was graduated from New York University School of Medicine in 1936 and practiced general medicine in Newark until 1942. After three years' service with the United States Air Force, he reestablished a practice in Hillside. In 1954, Dr. Rothgesser joined the staff of Blue Shield as Assistant Medical Director, became Associate Medical Director in 1961 and Medical Director in 1968. In addition he worked part time as chief of the diabetic clinic at Newark City Dispensary.

Dr. Isadore M. Schnee

On October 17, Isadore M. Schnee, M.D., a senior member of our Passaic County component, died at his home. A native of Austria, born in 1906, Dr. Schnee was graduated from the University of Aberdeen, Scotland in 1934 and pursued a career in otolaryngology, becoming board certified in that specialty. He was a Fellow of the American College of Surgeons and of the American Academy of Ophthalmology and Otolaryngology and held staff appointments at Barnert Memorial Hospital in Paterson, the Paterson Eye and Ear Infirmary, the Manhattan Eye and Ear Hospital, Beth Israel Medical Center in Passaic and Chilton Memorial Hospital in Pompton Plains. During World War II, Dr. Schnee served in the medical department of the AUS.

Dr. George C. Schwarzkoff

We recently learned of the death on November 1, 1979 of George C. Schwarzkoff, M.D., formerly of Atlantic City. Dr. Schwarzkoff was born in Germany in 1894 and earned his medical degree from the University of Koenigsberg in 1918. He emigrated to the United States in the 1920s and took graduate training in ophthalmology, becoming board certified in that specialty. He had been affiliated with the Atlantic City Hospital and with the Shore Memorial Hospital in Somers Point. Dr. Schwarzkoff was a recipient in 1968 of MSNJ Golden Merit Award, indicating fifty years of medical practice.

Dr. John M. Skeats

One of Essex County's well-known surgeons, John M. Skeats, M.D., of South Orange, died on October 19 at the Hospital Center at Orange. A native of New Jersey, born in 1916, Dr. Skeats was graduated from New York University Medical School in 1941 and after internship and graduate training earned board certification in his specialty and Fellowship in the American College of Surgeons. He established a practice in East Orange and had been affiliated with the Hospital Center at Orange, where he was president of the staff, and with St. Barnabas Medical Center in Livingston. He retired from active practice last year. During World War II Dr. Skeats served with the medical department of the United States Navy.

Dr. Anthony T. Stokes

One of Hudson County's senior members, Anthony T. Stokes, M.D., died on May 4. A native of Vermont, Dr. Stokes was graduated from the Medical School of the University of Vermont in 1934 and came to New Jersey to practice general medicine in Secaucus until retirement in 1973 to Deerfield Beach, Florida. Dr. Stokes had been on the staff at Christ Hospital in Jersey City.

Dr. W. Austin Tansey

W. Austin Tansey, M.D., formerly a member from the Essex County component, died at his home on August 26 after a long illness. Born in Newark in 1913, Dr. Tansey was graduated from Columbia University's College of Physicians and Surgeons, class of 1938, and pursued graduate training in internal medicine at Massachusetts General Hospital, becoming board certified in that field. He was a Fellow of the American College of Physicians and of the Academy of Medicine of New Jersey. He had been on the staffs of the Overlook Hospital in Summit, the Orange Memorial Hospital and the St. Barnabas Medical Center in Livingston. During World War II, Dr. Tansey served with the medical department of the United States Air Force.

Dr. Edgar M. Tennis

Word has been received of the death in August of Edgar M. Tennis, M.D., formerly an Englewood ophthalmologist, who had retired to Deer Island, Maine and more recently was living in Stuyvesant, New York. A native of Virginia, Dr. Tennis was graduated from the University of Virginia School of Medicine in 1921 and pursued graduate work in ophthalmology and otolaryngology. He had been affiliated with Englewood Hospital and was a member of the Bergen County Medical Society. Dr. Tennis was 83 years old at the time of his death. In 1971 he received MSNJ's Golden Merit Award, marking his fiftieth year in the medical profession.

Dr. Zoila R. Viciedo

A member of our Essex County component, Zoila Viciedo, M.D., of Newark, died suddenly on August 21 at Clara Maass Memorial Hospital, Belleville. A native of Havana, Cuba, Dr. Viciedo earned her medical degree from the University of Havana Medical School in 1950 and practiced there until emigrating to the United States in 1957. She took graduate training in pathology at the University of Oregon Medical School and St. Barnabas Hospital in Minneapolis, and in medicine at Polyclinic Hospital in New York and St. Barnabas Medical Center in Livingston. Dr. Viciedo was a family practitioner in Newark and was affiliated with Presbyterian and St. Michael's Hospitals there and with the Clara Maass Memorial Hospital in Belleville. Dr. Viciedo was 60 years old at the time of her death.

BOOK REVIEWS

Alcohol and Women. Research Monograph 1.

National Institute on Alcohol Abuse and Alcoholism. U.S. Dept. of Health, Education, and Welfare. Washington, D.C., U.S. Govt. Printing Office, 1980. (No price given).

More women are indulging in alcohol, and more are drinking to excess; alcohol abuse and alcoholism no longer are considered mainly problems of men, as they were prior to the seventies. As yet little research has been done on the many aspects of alcohol use and abuse in women, and it was fitting that the National Institute of Alcohol Abuse and Alcohol published, as the first in a series of research monographs, the proceedings of a Workshop held in Jekyll Island, Georgia, in April 1978 to discuss the state of the art concerning women and alcohol.

The major topics of the Workshop were epidemiology, biological and psychosocial consequences, risk factors—proneness and vulnerability, clinical research, and prevention and education research. A final chapter summarizes the recommendations of the participants under the headings of policy/administrative, methodological and substantive recommendations. Four resolutions were passed by the participants aimed at urging special research allocation in the area of alcohol and women, involving qualified women scientists and social scientists in such research, aiding less experienced researchers to prepare proposals and keeping review of all NIAAA proposals within NIAAA.

The majority of the participants appropriately were women; 22 women and five men are listed as invited guests and participants. NIAAA was represented by eight women and three men. One must regret that only five of the participants were physicians, including former NIAAA director Ernest P. Noble, Ph.D., M.D. The Workshop recommendations also had little to say about the role of the physician, except for his need to be educated to be more aware of female alcohol problems, and (with other health and mental health personnel) to be prepared to diagnose, treat and refer women and men with alcohol problems.

The Workshop reached its stated objectives, which were to discuss existing research, identify key issues and develop research priorities for NIAAA research efforts. A researcher seeking topics which need to be researched and which are eminently fundable by NIAAA will find many in this book.

A. Arthur Sugerman, M.D.

Review of Medical Pharmacology, 7th Ed.

F.H. Meyers, M.D., Ernest Jawetz, M.D., Alan Goldfien, M.D., Los Altos, CA, Lange, 1980. Pp. 747. Illustrated. ($17.50)

This is the 7th biennial edition of the *Review of Medical Pharmacology*. The book has been quite successful here and abroad, according to its authors, with editions already appearing in German, Italian, Japanese, Portuguese and Spanish, and French and Chinese translations in preparation. This wide acceptance is a comment not only on the quality of the text but also on the continuing influence of American medicine on worldwide teaching and practice.

The authors do a competent job in keeping their text up-to-date. They include some drugs used abroad but not yet available for prescription in the United States, such as the calcium antagonist verapamil and the newer sulfonylureas, as well as recently approved drugs. There are some understandable omissions, however, such as the use of propranolol for the prevention of common migraine headaches.

The *Review* is an expert reference for the practitioner and an excellent text for the student, providing much more than a simple review. There are skillful discussions of the basic mechanisms of drug action, metabolic pathways, and clarifying illustrations such as the ones provided to elucidate ocular pathophysiology under anticholinergic drugs. Adding to the overall value of this book are the general discussions on drug biodisposition and interactions, the clinical evaluation of drugs, toxicity of therapeutic agents, drug abuse and environmental toxic agents.

Hyman W. Fisher, M.D.

Physician of the American Revolution: Jonathan Potts.

Richard L. Blanco. Garland STPM Press, New York, 1979. ($27.50)

The recent Bicentennial inspired a host of publications about our Revolution, including a few devoted exclusively to the Medical Department of the Continental Army. The present work, based on the career of a dedicated young physician who rose rapidly to the rank of Deputy Surgeon-General, includes as a bonus a general survey of the activities of the medical service in the north. However, aside from some original material relating to Potts himself the book adds few new facts or insights not already included by Lewis C. Duncan in his *Medical Men in the American Rvolution*, written just half a century ago, or in the writings of Howard L. Applegate (Syracuse Ph.D. dissertation, 1961). Jonathan Potts, whose grueling experiences at Forts George and Ticonderoga well may have undermined his constitution and resulted in his untimely death, already had been the subject of an excellent, detailed thesis written by a young scholar, John W. Krueger of the University of Vermont (1974). Both Applegate and Krueger seem to have escaped our author's attention, since neither is listed in the otherwise adequate bibliography.

I find myself in mild disagreement with professor Blanco on several points: the trials of the medical apprentice have been overdramatized; in fact he was generally treated like family, and not infrequently ended up marrying the master's daughter or succeeding to his practice. Indeed, the preceptorship was such an ingrained institution in this country that it continued to flourish for more than half a century after the earliest American medical schools had been firmly established. Nor did the medical man ever derive 80 percent of his income from the sale of drugs, as the account books of our own Dr. Moses Elmer and others clearly will indicate. Only a general historian would write of gallbladder surgery in the eighteenth century; the author obviously was referring to the removal of stones from the urinary bladder; he strangely misuses the term 'herbal' when he talks of an herb or herbal medicine; on p. 162 he gives the American casualties at Germantown as 1,000—two pages later these are reduced to 650; the date of Dr. John Cochran's appointment as surgeon-general is incorrectly given as October 6, 1780 rather than January 17, 1781; Edward Jenner did not perform his first vaccination until 1796 rather than 1795; finally I have found at least one instance in which notes are misnumbered.

It is unfortunate that these and other evidences of hasty proofreading, combined with a tendency to repetition, mar an otherwise interesting text. For the general reader who would like to know more about the high motivation, struggles and accomplishments of such medical men as Jonathan Potts and his colleagues, as well as the unfortunate internal rivalries which beset the Medical Department and led to deplorable mortality statistics, this book provides a good introduction.

Morris H. Saffron, M.D.

Current Obstetric and Gynecologic Diagnosis and Treatment, 3rd Ed.

R.C. Benson. Los Altos, CA, Lange, 1980. Pp. 1001. Illustrated. ($21).

This third edition of *Current Obstetric and Gynecologic Diagnosis and Treatment* has achieved its main goal which is to provide updated, concise, and complete information related to the speciality. One of the principal accomplishments of this textbook is the skill used to summarize with sufficient detail. Not only are there standard chapters usually found in the textbooks of obstetrics and gynecology, but included are new subjects relevant to the modern practice of the specialty, such as pediatric and adolescent gynecology, psychological aspects of obstetrics and gynecology, medico-legal problems, applied genetics and genetic counseling, special medical and surgical conditions in gynecology and antimicrobial chemotherapy.

It was a pleasant surprise to review the chapter on breech presentation. With the current tendency to use cesarean section as the standard approach for breech presentation, most of the new obstetrical textbooks neglect to present in detail the vaginal delivery, depriving the new generation of obstetricians, who usually have minimal experience with the vaginal approach, of the appropriate description of these different techniques. Thorough knowledge is necessary because the current tendency of abdominal delivery may be reversed in the future and unexpected or unplanned vaginal deliveries may cause unnecessary harm to the mother and fetus. The number, quality and detail of the illustrations in which breech delivery is covered in the textbook are excellent.

One of the few drawbacks of the book is the poor quality of some of the photographs. For example, the vulvar and vaginal lesions fail to show the details of the lesions described. The same problem occurred with some pictures of operative specimens and microscopic illustrations. The use of colored pictures could have solved this problem.

It is the reviewer's opinion that this textbook is a "must" in the library of the busy clinician who requires rapid, concise, updated and still complete information pertaining to the management of his patient.

Marco A. Pelosi, M.D.

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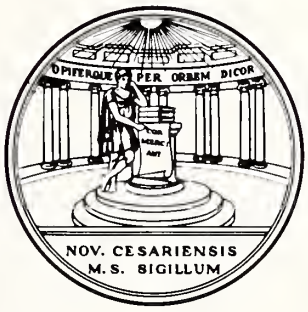

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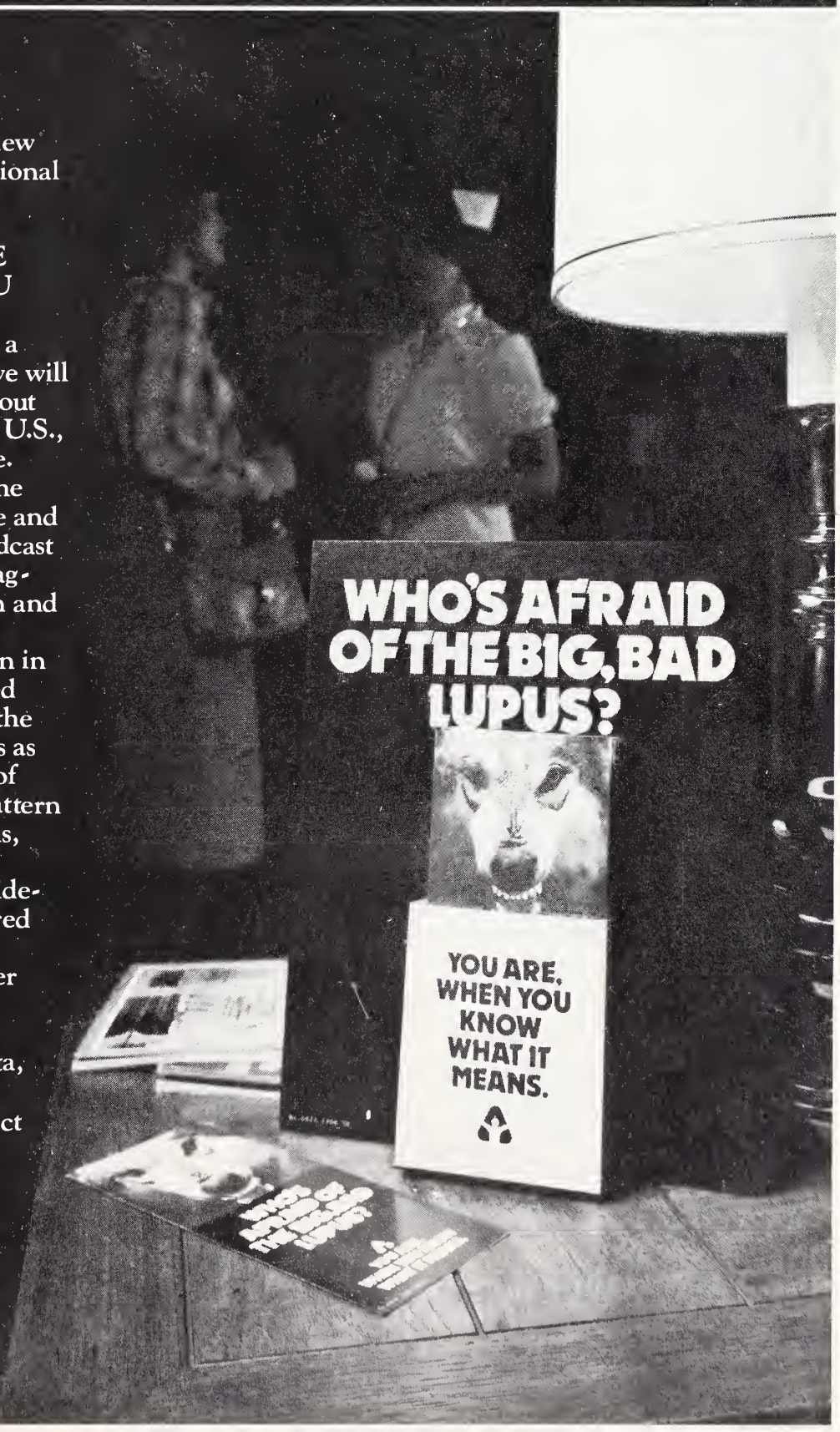

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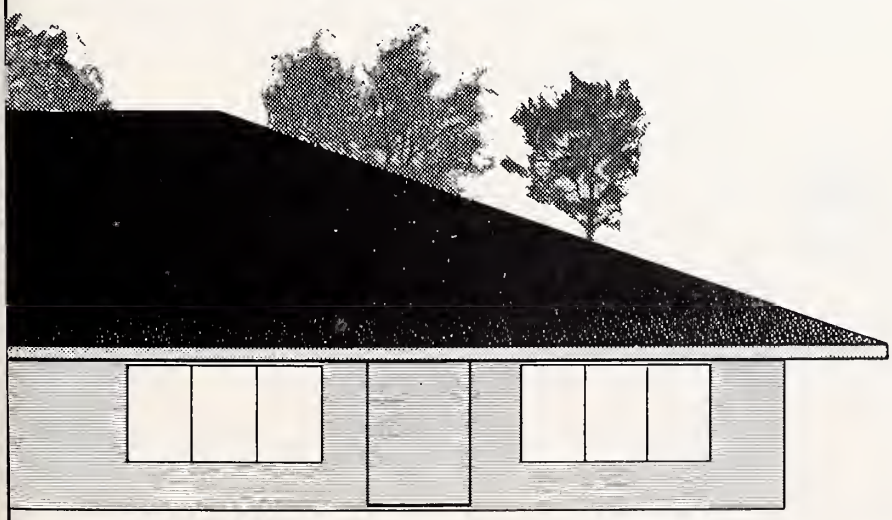

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1980

Journal of the Medical Society of New Jersey

TRANSACTIONS

1980 House of Delegates

214th ANNUAL MEETING

The Medical Society of New Jersey

May 11-14, 1980

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1979 Transactions

At its first session on Saturday, May 10, 1980, the House of Delegates approved the Transactions of the 1979 House of Delegates as published in the July 1979 Transactions issue of *The Journal,* and the Transactions of the Special Session of the House of Delegates held November 18, 1979, as published in the January 1980 issue.

Action To Limit Debate

At its first session on Saturday, May 10, 1980, the House of Delegates agreed, upon motion, that no one may speak more than once on any given subject except in rebuttal or by express permission of the House, and that floor time in each instance shall be limited to four (4) minutes unless exception is made by the House. This was limited to two (2) minutes for the Monday afternoon (May 12) session.

Reports and resolutions, and the actions thereon, are included under the Reference Committee to which they were assigned. The House takes action only on the "Resolved" sections of a resolution.

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The following resolutions were received by the House without referral to committee.

Introduced by: **Middlesex County Medical Society**

Subject: **COMMENDATION TO JAMES S. TODD, M.D.**

Whereas, James S. Todd, M.D., has exemplified himself as a true leader of medicine; and

Whereas, Doctor Todd is an outstanding citizen of the State of New Jersey; and

Whereas, Doctor Todd has been a member of the Board of Trustees of the Medical Society of New Jersey for nine years and its Chairman for the past five, and accomplished these tasks with love, devotion, and superior performance; and

Whereas, Doctor Todd's credentials as a surgeon are impeccable; and

Whereas, Doctor Todd will be the recipient of the Edward J. Ill Award of the Academy of Medicine of New Jersey for outstanding and unselfish dedication to medicine; and

Whereas, Doctor Todd is the Chairman of the Board of Directors of the New Jersey State Medical Underwriters' Inc., the company that administers the physicians' professional liability insurance plan; now therefore be it

RESOLVED, that the Medical Society of New Jersey endorses and recommends Doctor Todd as a Trustee of the American Medical Association; and be it further

RESOLVED, that the Medical Society of New Jersey wishes Doctor Todd every success and good fortune as a Trustee of the American Medical Association.

Adopted by acclamation

Introduced by: **Board of Trustees**
(5/13/80)

Whereas, in its recent actions, the House of Delegates has demonstrated a degree of skepticism toward the Board of Trustees; and

Whereas, the Board wishes to be responsive to the wishes of the membership; and

Whereas, there are circumstances where the Board must make decisions without the direction of the House; and

Whereas, the Board in those circumstances needs a mechanism to sample the will of the House; now therefore be it

RESOLVED, that the House of Delegates instruct each county society to have the chairman, or his designee, of their delegation attend each meeting of the Board of Trustees in order to participate in the decision-making process of the Board.

Unanimously adopted by the House.

REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

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Reports:
Committee on Revision of Constitution and Bylaws
Amendments to Bylaws

Revision of Constitution and Bylaws

Hillel M. Ben-Asher, M.D., Chairman, Morristown

(Reference Committee on Constitution and Bylaws)

PROPOSED AMENDMENTS TO THE BYLAWS

1. AMA and Medical Society of New Jersey Dues for Physicians

Resolution #9, adopted by the 1979 House of Delegates, calls for reduction in State and AMA dues by 50 percent for the physician's first year of practice post-residency in New Jersey. Current AMA policy grants this reduction. Therefore, only the Medical Society of New Jersey dues must be addressed.

BYLAWS
Chapter X—Finance

Section 1—Annual Assessment (Dues)

Current	*Proposed*
(b) Per capita assessments shall apply in the same manner immediately upon the admission or reinstatement of members, except that for a new member admitted after September first of any calendar year, only one-half (½) of the regular per capita assessment shall be levied. Every member for whom the per capita assessment is paid shall be entitled to receive such publications as may be issued by this Society for its members.	(b) Per capita assessments shall apply in the same manner immediately upon the admission or reinstatement of members, except that for a *member entering the first year of post-residency practice the Medical Society of New Jersey dues shall be 50% of regular dues.* For a new member admitted after September first of any calendar year, only one-half (½) of the regular per capita assessment shall be levied. Every member for whom the per capita assessment is paid shall be entitled to receive such publications as may be issued by this Society for its members.

It is the Committee's intent that those individuals who qualify for this reduction will receive the benefit of 12 full months of reduced dues.

The Committee on Revision of Constitution and Bylaws **recommends** adoption of this proposal.

Approved—Bylaw amendment was adopted.

2. Dues Collection

The House of Delegates, at the Special Session held on November 18, 1979, requested the development of a Bylaw change which would make dues payable by March 1, with termination occurring upon default.

BYLAWS
Chapter X—Finance

Section 1—Annual Assessment (Dues)

Current	*Proposed*
(c) If a member has not paid his annual assessment by June first, his name shall be dropped from the membership rolls.	~~(c) If a member has not paid his annual assessment by *March first*, his name shall be dropped from the membership rolls. *Reinstatement policy shall be established and approved by the Board of Trustees.*~~

The Committee on Revision of Constitution and Bylaws **recommends** adoption of this proposal.

Disapproved—Bylaw amendment was not adopted.

The Reference Committee felt that a reinstatement policy for lost membership should be established and approved by the Board of Trustees.

Adopted in accordance with the recommendation of the Reference Committee.

3. Delegate Apportionment

The House of Delegates, at the Special Session held on November 18, 1979, requested the development of a Bylaw change which affects delegate apportionment on the number of dues-paid members as of March 1, of the dues year in which the House is meeting.

Chapter 1—Membership

Section 2—List of Members
Subsection (b)

Current	*Proposed*
. . . Immediately after December 31 of each year, the Secretary of this Society shall notify each component society of the number of delegates to which it	~~. . . Immediately after *March 1* of each year, the Secretary of this Society shall notify each component society of the number of delegates to which it~~

is entitled during the next succeeding year in the House of Delegates, based on the number of active members recorded in the office of the Secretary on that date. Associate membership shall not be included in such computation.	~~is entitled during *that dues* year in the House of Delegates, based on the number of *paid regular* members recorded in the office of the Secretary on that date. Associate membership shall not be included in such computation.~~

The Committee on Revision of Constitution and Bylaws is of the opinion that adoption of this proposal will present awesome mechanical problems for the county medical societies. However, there is some merit in having the delegations restricted to dues paying members.

The Committee on Revision of Constitution and Bylaws **recommends** that this proposal **not** be adopted.

Approved—Bylaw amendment was not adopted.

4. Extension of Terms for AMA Delegates and Alternates

The 1979 House of Delegates adopted Resolution #4, which called for the development of a Bylaw change to authorize the AMA delegation to recommend to the House that a specific delegate or alternate be permitted additional terms because he/she is a likely candidate for AMA office.

BYLAWS

Chapter VI—Other Delegates and Representatives

Current	*Proposed*
(a) American Medical Association	(a) American Medical Association
. . . No member shall serve more than three two-year terms as an AMA Delegate. Likewise, no member shall serve more than three two-year terms as an Alternate Delegate.	(1) No member shall serve more than *six* two-year terms as an AMA Delegate *or Alternate, or any combination thereof.*
	~~(2) *The House of Delegates, upon petition from the AMA Delegation that certifies a given Delegate or Alternate is a candidate for the AMA Board of Trustees, the Office of Speaker or Vice-Speaker of the House, or the Office of President-Elect, may vote to suspend the limitation on tenure of that particular delegate.*~~

The Committee on Revision of Constitution and Bylaws **recommends** that paragraph (1) be adopted.

Approved—Paragraph 1 (above) of the Bylaw Amendment was adopted.

The Committee felt that paragraph (2) was unnecessary due to the proposed change in paragraph (1) and **recommends** that paragraph (2) **not** be adopted.

Approved—Paragraph 2 (above) of the Bylaw Amendment was not adopted.

5. Duties of the Treasurer

At the 1979 Special Session, the House of Delegates voted to request the preparation of new Bylaws detailing the function of the Treasurer.

BYLAWS
Chapter V—Officers

Section 3—Rights and Duties of Officers

Current	*Proposed*
(d) The Treasurer shall be under bond, at the expense of this Society, in such amount as may be required by the Board of Trustees.	(d) The Treasurer shall be under bond, at the expense of this Society, in such amount as may be required by the Board of Trustees.
He shall demand and receive all funds due this Society, and shall preserve all funds of this Society.	*The Treasurer shall have general supervision of the financial affairs of the Society.*
He shall receive requests and donations, and maintain a complete record thereof.	*He shall cause to be collected all dues and assessments and shall supervise established accounting and investment procedures for the handling of the Society's funds. He shall report on the financial condition of the Society to the House of Delegates at each Annual Meeting.*
He shall not pay money out of the treasury except (1) in amounts as provided in the annual budget, upon voucher of the officer or committee responsible for the expenditure, or (2) in amounts as provided by resolution of the Board of Trustees and for which voucher has been prepared. All such vouchers shall be approved and signed by the chairman of the Committee on Finance and Budget.	*At the end of each fiscal year, he shall cause to be prepared an annual audit conducted by an external certified public accountant.*
He shall render at each annual meeting of this Society a full statement of all transactions of the Treasurer's office.	
He shall notify the proper officer or committee chairman whenever ninety percent (90%) of the annual appropriation for any office or committee has been expended.	
He shall collect and enter proper credits for per capita assessments received from component societies.	
He shall perform such other duties as may be assigned by the House of Delegates or the Board of Trustees.	
He shall submit his accounts for audit at such times as the House of Delegates or the Board of Trustees may order.	

The Committee on Revision of Constitution and Bylaws **recommends** that the proposal be adopted.

Approved—Bylaw amendment was adopted.

6. Annual Operating Budget

At the 1979 Special Session, the House of Delegates voted to have Bylaw proposals for budget adoption prepared for their consideration in May, 1980.

BYLAWS
Chapter X—Finance

Section 2—Per Capita Assessment

Current	*Proposed**
(a) At the call of the chairman of the Committee on Finance and Budget, officers and committee chairmen shall submit an itemized estimate of the amount of money necessary for their official or committee's activities during the next fiscal year.	*The House of Delegates with recommendations developed by the Committee on Finance and Budget and reviewed by the Board of Trustees, shall adopt an annual operating budget for the next fiscal year. The House of Delegates shall determine the annual dues for all members.*
(b) The Committee on Finance and Budget shall then proceed to consider and determine the amount of money to be raised by the per capita assessment to be levied on the component societies.	
(c) The recommendations of the Committee on Finance and Budget shall be reported to the House of Delegates at the first session of that body, together with any recommendations of the Board of Trustees after review.	
(d) The House of Delegates may approve, amend, or reject the report, but final action on it shall not be taken until the last session of that body.	

* Adoption of the proposed amendment would delete subsections a, b, c and d.

The Committee on Revision of Constitution and Bylaws **recommends** that the proposal be adopted.

Approved—Bylaw amendment was adopted.

7. Expenditure of Funds in Excess of Budgetary Appropriations

Since the current section of the Bylaws represents a concept that is not utilized and does not serve any practical purpose, the Committee considered the following proposal recommended by staff.

BYLAWS
Chapter X—Finance

Section 3—Annual Budget

Current	*Proposed*
(a) No officer or committee may spend more money than the amount allowed in the budget. The Board of Trustees may, however, apportion to any officer or committee, on application, any unexpended balance from other items, provided that the total annual budget voted by the House of Delegates is not thereby exceeded.	*The Board of Trustees shall have the power to authorize the expenditure of funds in excess of budgetary appropriations.*
(b) The Board of Trustees shall have the power to authorize the expenditure of funds in excess of budgetary appropriations in accordance with these Bylaws.	

The Committee on Revision of Constitution and Bylaws **recommends** adoption of this proposal.

Original proposed amendment and Reference Committee suggested amendment referred back to Committee on Revision of Constitution and Bylaws for reconsideration and report at the next meeting.

8. Duties of the Speaker of the House of Delegates

The Board of Trustees requested the Committee to study the problems the Nominating Committee has had recently in functioning under *Sturgis*. It has been suggested that the Speaker of the House might serve as an advisor to the Nominating Committee. It was further requested that an evaluation be made of the duties of the Speaker of the House between annual meetings for report to the Board during this administrative year.

BYLAWS
Chapter II—Meetings

Section 2—House of Delegates—Meetings

Current	*Proposed*
(b) Speaker and Vice-Speaker	(b) Speaker and Vice-Speaker
The President shall have the power to appoint a Speaker of the House of Delegates at each annual meeting. The Speaker shall be a member of this Society, and his sole duty shall be to preside at the sessions of the House of Delegates. He shall not have the power to appoint committees.	*The President shall have the power to appoint a Speaker of the House of Delegates. The Speaker shall be a member of this Society. He shall preside at the sessions of the House of Delegates. He shall act as a parliamentarian to the Chairman of the Nominating Committee at meetings of that committee. He shall not have the power to appoint committees.*
The President shall also have the power to appoint a Vice-Speaker of the House of Delegates at each annual meeting. The Vice-Speaker shall be a member of this Society, and his duty shall be to assist the Speaker in presiding at the sessions of the House of Delegates. He shall not have the power to appoint committees.	*The President shall also have the power to appoint a Vice-Speaker. The Vice-Speaker shall be a member of this Society and he shall assist the Speaker in all his duties or in his absence shall act as Speaker. He shall not have the power to appoint committees.*

The Committee on Revision of Constitution and Bylaws **recommends** that the proposal be adopted.

Approved—Bylaw amendment was adopted.

9. Specialty Society Representation in the House of Delegates
Medical Student Representation in the House of Delegates

The Board of Trustees requested that the Committee study and report on both the question of specialty society representation in the House of Delegates and medical student representation in the House of Delegates.

The Medical Society of New Jersey's corporate charter, which was originally enacted in 1790 and amended several times since then, provides that ". . . the said society shall be composed of delegates (not less than three) chosen by and from each of the districts or county societies, which now are, or which under the authority of the said society may be

hereinafter instituted . . ." (Revised Charter, March 14, 1864)

Based upon the foregoing, the Committee felt that it was not appropriate to recommend a Bylaw amendment at the present time. However, should the House of Delegates so desire it could direct the Board of Trustees to seek a change in the Charter to accomplish the redistribution of delegates suggested in the referrals.

The Committee further suggests that consideration be given to inviting presidents of specialty societies to attend the sessions of the House with the privilege of addressing the House but without the right to vote.

10. Resignation or Removal from Elective or Appointive Positions

The Committee noted that the current Bylaws do not provide for removal of individuals from elective or appointive positions between annual meetings.

BYLAWS
Chapter V—Officers

Section 3—Rights and Duties of Officers

Current	*Proposed*
(f) Resignation or Removal	(f) Resignation or Removal
Any Officer of this Society may resign. He may be removed from office by action of the House of Delegates, if found guilty by that body of neglect of duty, improper conduct, or violation of the Constitution and Bylaws. A two-thirds (2/3) vote of the delegates present and voting shall be required to effect such removal.	Any Officer of this Society may resign. He may be removed from office by action of the House of Delegates, if found guilty by that body of neglect of duty, improper conduct, or violation of the Constitution and Bylaws. A two-thirds (2/3) vote of the delegates present and voting shall be required to effect such removal. *Any Officer, Committee member, Council member, or anyone holding an elective or appointive position within the Medical Society of New Jersey may be removed by the Board of Trustees for good cause at any time the House of Delegates is not in session. A two-thirds (2/3) vote of the Trustees present and voting shall be necessary to effect such removal.*

The Committee **recommends** that the proposal be adopted.

Approved—Bylaw amendment adopted.

The question of establishment of due process by an appeal to the Judicial Council was referred to the Committee on Revision of Constitution and Bylaws for consideration.

REFERENCE COMMITTEE "A"

Paul J. Hirsch, M.D., Somerset
Chairman
Harry W. Fullerton, Jr., M.D., Salem
Francis X. Keeley, M.D., Camden
Aris M. Sophocles, M.D., Mercer
George A. Zazanis, M.D., Morris
David A. Gehring, M.D., Gloucester
Alternate Member

Reports:
President
Board of Trustees
Secretary
Judicial Council
Executive Director
Committee on Credentials
Committee on Long Range Planning and Development
(AMA) Ad Hoc Committee on Principles of Medical Ethics

President

Alfred A. Alessi, M.D., Hackensack

(Reference Committee "A")

It has been my privilege to serve the Medical Society of New Jersey this year as President. My duties are to describe accomplishments of the Society during the year, list possible projects and policies for the future, and make recommendations.

At the beginning of the year, relations with the State Board of Medical Examiners were at a low point. By meetings and communications this was reversed. We now are working with mutual respect, understanding that our objectives are the same—better medical care for our patients. The President-Elect, a member of the Board of Trustees, and a member of the executive staff of the Medical Society attend all meetings of the State Board of Medical Examiners and report regularly to the Board of Trustees. All problems have not been resolved. Physicians continue to express concern about the process when they are asked to appear for a hearing before the State Board because of disciplinary matters. Confusion still exists about approval of the Society's continuing medical education program by the State Board of Medical Examiners. The State Board approved our program by resolution early in the year, but when the AMA withdrew from the Liaison Committee on Continuing Medical Education, the State Board approved the LCCME. Negotiations between the LCCME and the AMA, now underway, may resolve the problem. The many areas of cooperation between the Medical Society of New Jersey and the State Board of Medical Examiners, such as the impaired-physician program, drug interactions and fee disputes, indicate that a very satisfactory relationship has developed.

Problems exist in keeping physicians up-to-date with information on drug incompatibility. An ad hoc committee will be appointed to solve this problem.

County executives requested a combined meeting to resolve mutual problems in their relations with the State Society. A satisfactory meeting was held in the Fall of 1979 and another meeting is scheduled for the Spring of 1980. A main problem seems to be the time of dues' collection and reimbursement to the State Society. A mechanism for exchange of information between the counties and a forum for discussion has been established.

The composition of the House of Delegates of the Medical Society of New Jersey has been reviewed by the Board of Trustees and the Special Committee on Long Range Planning and Development. The unwieldy size of the House and poor attendance figures from some areas justify a reduction. A recurring complaint of the specialty societies seems to be that they are not represented fairly in the House of Delegates. The Board of Trustees recently approved a recommendation that the Bylaws be changed to secure adequate representation for the specialty societies.

A significant development has been the organization of a good negotiation process to resolve disputes between specialty societies and physicians in general. Battles must be avoided and unity is essential. Physicians carefully should review the Committee on Negotiations' Policy Guidelines and Procedures for Negotiations adopted by the Board of Trustees, and included in the Board's annual report.

The Diagnosis Related Group (DRG) method of hospital reimbursement became law as of January 1, 1980, with 26 hospitals mandated to be involved. In view of the potential impact on the practice of medicine, a resolution was presented and approved by the AMA House of Delegates to monitor the project carefully. We will continue to have the State Society follow the DRG system in New Jersey and report periodically to the AMA.

Monthly reports were received from Stanley S. Bergen, Jr., M.D., President of the College of Medicine and Dentistry of New Jersey, and reviewed by the Board of Trustees. Doctor Bergen is to be congratulated on the thoroughness of these reports. Relationship with the College has improved greatly over the previous year. At present, Doctor Bergen is drawing up a white paper (for our use) on the AMA Council on Medical Education's report on possible revisions of medical education at all levels. This important document should be studied by all.

A "Conflict of Interest" report was adopted as the official position of the Medical Society of New Jersey. This problem has been plaguing thoughtful people in the Society for years.

The Joint Practice Committee with the New Jersey State Nurses' Association has been active. One constructive accomplishment has been the Nurses' Association agreement at their annual meeting that there should be multiple methods of education and entrance into the nursing profession.

AMA recruitment has been studied carefully by the Ad

Hoc Committee on Membership and Dues Collection. This is a vital program as the AMA is the only body that protects the physician on the federal level. This requires membership support and money to be effective.

State regulation of medical practice has become increasingly important. It is contemplated that state regulation will supersede federal regulation in activity. Therefore, it is important that the Medical Society convey a unified opinion on issues to state legislators and that medical organizations unite to this end. We cannot create confusion in legislators' minds and be effective in influencing legislation.

Finally, the Society continues to be active in the state legislative area. Plans for reorganization and revitalization of the Jersey Medical Political Action Committee (JEMPAC) have been developed. They include assignment of an executive staff person to JEMPAC.

Legislators have been presented our views on physician assistants. Many problems continue with ancillary personnel wanting to practice medicine. This will have to be watched carefully.

At a state hearing on national health insurance, and at a Congressional meeting in Washington, D.C., the current view of the AMA on this subject also was presented as the policy of our State Society.

The following problem areas remain to be studied and resolved:

1. Statewide review of Health System Agency (HSA) activities.
2. Reimbursement for psychiatric patients.
3. Degree designation on license to practice.
4. Review and revision of the State Department of Health's Emergency Medical Services Task Force reports.
5. AMA membership recruitment.

Actions already taken by MSNJ which should be ongoing are:

1. Negotiate and review with the State Board of Medical Examiners rules and procedures for fair hearing when a physician is investigated. If necessary, seek legal opinions about the process and review them with the Attorney General of the State.
2. Report to the State Board of Medical Examiners results of the ad hoc committee developing a format for keeping physicians informed on drug incompatibility.
3. Continuation of biannual meetings between the county and state executive staff with published agenda and monitoring by a presidential officer.
4. Distribution of approved negotiating processes to specialty societies and county societies for use by their members.
5. Review of the AMA's Council on Medical Education report on possible revision of medical education by the Committee on Education and the House of Delegates of the Medical Society of New Jersey, with instructions to the AMA Delegation for MSNJ's suggestions for approval or revision.
6. Establishment of a process for statewide review of HSA activities.
7. Structuring of a program with the State Department of Health and the New Jersey Hospital Association to educate physicians in New Jersey hospitals on the aspects and implications of the DRG system.

Filed in accordance with the recommendation of the Reference Committee.

Board of Trustees

James S. Todd, M.D., Chairman, Ridgewood

(Reference Committee "A")

Once again it is my responsibility and honor to report on the activities of the Board of Trustees for the past year. As might be expected, there have been successes and frustrations during the year, but no major setbacks. Relationships with State regulatory agencies and our specialty societies continue to require constant attention. The special meeting of the House of Delegates in December demonstrated how intricate these relationships are.

It has been a disappointment for the Board that, despite monthly invitations and sharing of advance information, few county and specialty society representatives routinely attend Board meetings where direct input into the decision-making process could best occur. Now there are those who would seat specialty society delegates in the House of Delegates, believing this would better represent specialty interests. Since the House meets only once or twice a year, the interim problems would remain, and still would be better addressed by participation at the Board level. All specialties are well represented in the House and on the Board already, and to further divide and fragment the interests of the House would serve little purpose. The Medical Society exists to represent physicians, some of whom happen to be specialists. This fact should never be forgotten, and parochial interests can and should be blended into the greater interest of the profession.

Statewide, the Society enjoys improving relationships with the regulatory agencies. An objective, cooperative study of the Diagnosis Related Group (DRG) system of reimbursement, sponsored by the Hospital Research and Educational Trust (HRET) of New Jersey, involving the Hospital Association, Medical Society, State Department of Health, and the public sectors, will evaluate not only the validity of DRGs, but will solidify lines of communication so vital to pursuing our interests.

The State Board of Medical Examiners has been widely criticized in many forums, but Society relationships were never better. Representatives of our Board attend their meetings, and are increasingly used as advisors. The Committee on Impaired Physicians has a sound, working relationship with the Board, and mechanisms are being developed for peer review of complaints before they reach the administrative process. The Society is investigating a mechanism whereby physicians summoned before the State Board

will have automatic legal representation and advice. No one enjoys the regulatory process, but adversary positions produce little progress. The Society is committed to cooperative solutions of the medical regulatory process.

While still fraught with inequities, Medicaid remains under constant review, with meaningful relationships being developed. Discussions as to the techniques of regulatory activities are underway, and it seems certain that the progress already made will continue. The Board is appreciative of the dedicated service of the Committee on Medicaid and continues to support rational discussion and alteration of the Medicaid system.

Strengthening organized medicine remains a priority of the Board, and there is no better source of strength than the student and resident pool. Procedures are underway to allow seating of students in the House of Delegates and to develop a resident section. While this does not diminish the need to recruit practicing physicians to our ranks, the early habits of participation are bound to be beneficial. No opportunity should be lost to swell the ranks representing medicine, thereby assuring its preservation under the free enterprise system.

Last year osteopathic education was a major issue; this year it is those osteopaths assimilated into medicine via American Medical Association-approved residency training requesting the use of the M.D. designation as a generic indicator of competence. The State Board of Medical Examiners and the Osteopathic Society are entering litigation as to the correct designation to place on one's license. The issue is a difficult one, and must be handled with some delicacy if conflict between osteopaths internally, and between osteopaths and allopaths is to be avoided. The Board has directed that this be addressed through a joint meeting of all parties involved.

Since this will be my last report as Chairman of the Board, it seems appropriate to make some general comments regarding the Society. Having traveled extensively about the country, I have gained the distinct impression that the Medical Society of New Jersey is one of the more stable and responsive societies. We owe a great debt to Mr. Vincent A. Maressa for his dedication and ability as our Executive Director; also for his development and direction of our superb administrative staff guaranteeing a smoothly functioning and effective organization. Without the able assistance of Ms. Diana Gore, the chairmanship of the Board easily could become a shambles. I am indebted to all the many people who make the Society go, but most of all to the Board whose fidelity and ability never were lacking. It has been a distinct honor and pleasure to serve, and I leave confident that your Medical Society is well served by its elected officials and administrative staff.

Filed in accordance with the recommendation of the Reference Committee.

Other matters occupying the Board's attention were:

AMA MEETINGS
(Reference Committee "A")

The New Jersey Delegation believes the AMA is increasingly responsive to important issues, and that New Jersey's input into the process has been effective.

In order more fully to absorb and influence the national activities, and to develop a better understanding among the membership, the Delegation recommended, and the Board of Trustees concurred, that the Society's executive staff department directors, and any administrative staff necessary to support their functions, should routinely attend the AMA Annual and Interim Meetings and the National Leadership Conference.

The Delegation also recommended that county medical societies should be encouraged to send their executive staff to the same meetings.

Filed in accordance with the recommendation of the Reference Committee.

AMA MEMBERSHIP
(Reference Committee "A")

The Board of Trustees believes that the best interests of the practicing physician require a strong and unified AMA. After years of studying this problem, the Board has come to the conclusion that the best approach to a physician is through his hospital medical staff.

Presidents of County Medical Societies were requested to develop within the medical staff of each hospital in their counties a small group of physician volunteers to recruit physicians into the AMA. Progress reports on this activity will be presented to the House of Delegates on a regular basis.

Filed in accordance with the recommendation of the Reference Committee.

DUE PROCESS HEARINGS
(Reference Committee "A")

The Board of Trustees has been receiving an increasing number of requests from physicians to support them financially or otherwise to assist them in disputes arising with their hospital's board of trustees or administrators. Virtually all of these cases involve an arbitrary abridgement of the rights of the staff physician via denial of due process hearings.

It is the belief of the Board of Trustees that these problems first must be considered by local sources before being brought to the State Society. Hopefully, they will be resolved locally.

The hospital medical staff and internal hospital system must be the first course. Discussion with the county medical society would be the next level. If necessary, consideration by the Medical Society of New Jersey then would follow.

Filed in accordance with the recommendation of the Reference Committee.

GAS RATIONING FOR HEALTH PERSONNEL
(Reference Committee "A")

The AMA House of Delegates agreed with the Society's resolution regarding assurance of ample gasoline supplies for health professionals, but adopted a report from the Board which indicated that the AMA will continue to monitor the situation and work with government and private agencies.

Filed in accordance with the recommendation of the Reference Committee.

LICENSURE REVOCATION PROCEEDINGS BEFORE THE STATE BOARD OF MEDICAL EXAMINERS
(Reference Committee "A")

The Board of Trustees has been concerned for some time with the system that is used in New Jersey to regulate the practice of medicine and to discipline physicians.

After conducting an in-depth study of the legal and political concepts involved, the Board concluded that the Society must offer the membership a vehicle to place them on a parity with the Office of the Attorney General.

In this regard, with the assistance of Steven I. Kern, Esq., a legal service plan was developed to serve the needs of the membership. A description of the plan, along with an application form and return envelope, will be mailed to the membership in March.

Filed in accordance with the recommendation of the Reference Committee.

MEMBERSHIP IN A PROFESSIONAL SOCIETY AS A REQUIREMENT FOR HOSPITAL STAFF APPOINTMENT

(Reference Committee "A")

The Medical Society of New Jersey has taken the position that medical staffs should consider membership in a professional society as a requirement for staff appointment.

Legal Counsel has indicated that no legal impediment is involved and has substantiated the legality of establishing membership in a professional society as a reasonable criterion for admission to a hospital medical staff.

To illustrate the involvement of an outside entity in hospital medical staff requirements, many hospitals require attending physicians to be board certified or board eligible.

Involvement in an assignment by only members of a professional society is borne out by the use of members of the Medical Society of New Jersey on the Supreme Court professional liability subpanels.

The significant point with respect to the legality of a bylaw requirement is that the court will, in all likelihood, honor a regulation that applies the "rule of reason," and if fairness and due process have been afforded.

Members of the Board have been urged to voice a positive attitude at staff meetings regarding the inclusion of such a provision in hospital bylaws.

Filed in accordance with the recommendation of the Reference Committee.

NEW JERSEY INTERPROFESSIONAL COUNCIL

(Reference Committee "A")

In August the Board agreed that it would not be of value for the Medical Society of New Jersey to join the New Jersey Interprofessional Council, but voted to support the concept that professionals should stand together and agreed to work with the Council when issues of the group and the Medical Society of New Jersey parallel.

Filed in accordance with the recommendation of the Reference Committee.

OSTEOPATHIC ASSOCIATION/DEGREE DESIGNATION ON LICENSE

(Reference Committee "A")

A resolution was developed on the part of certain osteopaths that: "Physicians licensed to practice medicine and surgery in the State of New Jersey, who have successfully completed any postgraduate training in an AMA-approved program of at least two years, and who have staff privileges in an AMA-approved hospital and are members of the county medical society in which their practice is located, should have the right to use the designation M.D. in place of D.O. in all of their activities and correspondence."

An Ad Hoc Committee on Degree Designation was appointed to study the problem. Those appointed to the Committee were: Sherman Garrison, M.D., Chairman, Frank Campo, M.D., Allen R. Griggs, D.O., John S. Madara, M.D., Hormoz M. Minoui, M.D., and Aris M. Sophocles, M.D.

The basic problems were reported to be that:

1) D.O.s skilled in the practice of manipulative therapy wish the public to be aware that they are so trained. Doctors of Osteopathy who no longer use manipulative therapy in their specialty practices (many of whom have been trained in allopathic hospitals) find themselves embarrassed by patients seeking manipulative therapy when they are no longer skilled in this form of therapy.

2) Doctors of Osteopathy are fully trained in the practice of medicine whereas limited practitioners are not so trained.

3) M.D.s are increasingly aware of the appropriate uses of bio-mechanics and manipulative therapy in treatment, as is the public. However, the public is usually poorly informed in regard to the exact role of limited practitioners in medical treatment.

Consideration was given to the following basic facts:

- There is a growing understanding between the Medical Society of New Jersey and the Osteopathic Association regarding mutual interests and management of patients.
- Licensure of both groups is identical in the State of New Jersey.
- There is general acceptance by the public and hospital staffs that the two groups are fellow practitioners.
- An increasing number of students at the CMDNJ-Rutgers Medical School is interested in the programs of bio-mechanics given by the D.O. section of the School.
- Many M.D.s have utilized the services of D.O.s in the practice of manipulative therapy.
- Personal relations between Doctors of Osteopathy and Allopathy never have been on a more fraternal level than at present.
- Few remember a similar problem which existed sixty years ago between Homeopaths and Allopaths, or how it was resolved.
- The problems regarding the status of limited practitioners on hospital staffs are faced by both Allopaths and Osteopaths.
- Doctors of Osteopathy who are skilled in body mechanics desire to have the public aware of this. (FTC rules may make it imperative that this information be made available to the public.)
- Allopaths and Osteopaths are the only fully-licensed practitioners of medicine at the present time.
- The use of the term M.D. has now become a generic term and in many instances is unrelated to the granting of an academic degree.
- In New Jersey a specific degree may be granted by the College of Medicine and Dentistry of New Jersey (and by charter awarded to the Medical Society of New Jersey). However, the degree cannot be granted by the State Board of Medical Examiners.
- The designation of "M.D." by the state licensing authority on licenses issued to foreign medical graduates to practice in the United States does not refer to an academic degree in all cases, since many of these graduates do not have academic degrees which translate into "M.D."
- Historically, the title "M.D." was commonly used to refer to the occupation rather than an academic degree.

In order to assure equal professional treatment of all individuals with comparable education and training, who meet the requirements for full and unrestricted licensure as physicians and surgeons, the Board approved the Committee's proposal that a conference be held with the represent-

atives of the New Jersey Association of Osteopathic Physicians and Surgeons, the State Board of Medical Examiners, the Department of Higher Education, the College of Medicine and Dentistry of New Jersey, and the Medical Society of New Jersey to consider this matter.

Additional information will be forthcoming.

Filed in accordance with the recommendation of the Reference Committee.

PHYSICIAN ASSISTANT PROGRAM
(Reference Committee "A")

New Jersey introduced a resolution at the AMA Annual Meeting calling for a reevaluation of the AMA position of support for physician assistant programs. The House adopted the resolution and directed the Board of Trustees to submit a report at the 1979 Interim Meeting.

Report J of the Council on Medical Services informed the House in July of the formation of a task force representing the Council on Legislation, the Council on Medical Education and the Council on Medical Services which will reevaluate the AMA position.

Filed in accordance with the recommendation of the Reference Committee.

SERVICES AVAILABLE TO SPECIALTY SOCIETIES
(Reference Committee "A")

Presidents of New Jersey specialty societies were notified of services available through the Medical Society of New Jersey and its related corporations.

The Society offers active participation to specialty societies through attendance at the monthly meetings of the Board of Trustees and the regularly scheduled meetings of the Council on Legislation, Committee on Medicaid, and Committee on Medical Education.

Administrative services may be contracted for through the Academy of Medicine of New Jersey. Meeting and function rooms are available through the Medical Society of New Jersey's Executive Offices.

Filed in accordance with the recommendation of the Reference Committee.

SPECIALITY LISTINGS IN THE YELLOW PAGES
(Reference Committee "A")

In February, the Board forwarded a communication to the President of the State Board of Medical Examiners indicating that the Society is concerned with the propriety of physicians listing themselves as specialists in the yellow pages of telephone directories when they are neither board eligible nor board certified.

The letter pointed out that there are many nuances to the question. The primary issue is the protection of the public and its right of access to necessary information. The second area is what really is meant by "board eligible"; and finally, what should be done in the event the physician does not fit into either category, but simply carries a listing of "Practice Limited to General Surgery."

The State Board was asked to determine what types of listings are permissible.

In response, the State Board indicated that as long as a physician specialized in a particular branch of medicine he could list accordingly and would not have to be board eligible or board certified. In this same regard, it is the State Board's opinion that any listing could not be false or misleading but must be truthful and the physician must, in fact, specialize or he would be in violation of N.J.A.C. 13:35-6.13, "Provision of Information to the Public Rule."

Filed in accordance with the recommendation of the Reference Committee.

Supplemental Report #1

OSTEOPATHIC ASSOCIATION/DEGREE DESIGNATION ON LICENSE
(Reference Committee "A")

The Board of Trustees received a written report on this issue from Sherman Garrison, M.D., on a meeting he attended on February 27, at the request of the Chancellor of Higher Education.

General discussion at the meeting appeared to support the concept that the integrity of the M.D. and D.O. degrees should be maintained. There appears to be no procedure at present to transfer from one degree to the other.

Evaluation of the use of the term "M.D." on licenses by the State Board of Medical Examiners for equivalent degrees was deferred pending the resolution of litigation addressing this matter.

Filed in accordance with the recommendation of the Reference Committee.

Supplemental Report #2

EVALUATION OF THE MEDICAL SOCIETY OF NEW JERSEY
(Reference Committee "A")

In July 1979, the Executive Director requested the American Society of Association Executives to work with the Medical Society of New Jersey on an evaluation of the organization.

The evaluation was conducted by a team of experienced and objective association executives who spent two days at the headquarters conducting several in-depth interviews with the Society's staff and leaders. In advance of the visit, the team members reviewed materials and information supplied by the Society. This information included: articles of incorporation, bylaws, budgets, audit, personnel manual, minutes of the House of Delegates, publications, meeting programs, organizational chart, and descriptions of committee activities.

Copies of the evaluation were supplied to the Board and the following actions were taken by the Board of Trustees at its April meeting:

a. Copies of the evaluation report will be sent to the component societies for review and comment.

b. A survey of the membership will be conducted by Stanford University to determine how members perceive the Society.

c. Copies of the report will be supplied to the Committee on Revision of Constitution and Bylaws and the Committee on Long Range Planning and Development for review and comment.

d. Copies of the report will be supplied to the executive staff for review and comment.

A progress report will be presented to the Board of Trustees in October.

Filed in accordance with the recommendation of the Reference Committee.

Secretary

Arthur Bernstein, M.D., East Orange

(Reference Committee "A")

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, minutes of Board of Trustees' meetings, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

MEMBERSHIP

(as of December 31, 1979)

Active: Paid	7,803	
Exempt	845	8,648***
*Associate: Paid		0
**Affiliate: Paid		81
Exempt		3
State Emeritus		581
Total of Above		9,313
State Honorary		8
New and Reinstated Members:		
Active		511
State Emeritus		1
*Associate		1
**Affiliate		2
Change of Status		9
Transfers within the state		39
Transfers out-of-state and resignations		127
Members deceased		119
Members dropped:		
Active (non-payment of dues)	129	
(did not comply with Bylaw requirements regarding Continuing Medical Education)	151	
(N.J. Licensure suspended)	5	
(N.J. licensure voluntarily surrendered)	1	
**Affiliate (non-payment of dues)	2	288

AMA MEMBERSHIP

A total of 6,254 members of the Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates stands at seven delegates—one for each thousand members, or fraction thereof.

MEMBERSHIP DIRECTORY

As of January 31, 1980 there were 1,200 copies of the 1979 Membership Directory on hand. During the period June 1, 1979 to January 31, 1980, 163 copies were distributed to new and reinstated members and 296 copies were sold to other individuals or organizations.

Efforts are being made at this time to produce a revised 1981 Membership Directory during late 1980 or early 1981.

*Associate membership (non-licensed in N.J.) designates interns and residents.

**Affiliate membership—physicians who no longer practice in New Jersey.

***Adjusted for transfers out-of-state, resignations, and deaths.

Filed in accordance with the recommendation of the Reference Committee.

Judicial Council

Albert F. Moriconi, M.D., Chairman, Trenton

(Reference Committee "A")

The Judicial Council has maintained its schedule of regular monthly meetings. From the official findings, the Council here presents a summary of its operations and those of county judicial committees for the period from April 1, 1979 through March 28, 1980.

By Judicial Committees

Complaints reported as disposed of	49
Alleging:	
Dissatisfaction concerning fees	21
Unprofessional conduct	14
Dissatisfaction concerning medical procedures	7
Dissatisfaction concerning professional ethics	7

By the Judicial Council

Meetings held	5
Official communications acted upon	43
Appeal hearings requested	9
Appeal hearings granted	1
Formal opinions rendered	1

ETHICAL PROCEDURES IN SECOND SURGICAL OPINIONS

(Officially Adopted January 23, 1980 as MSNJ Opinion #27)

The following Opinion (MSNJ Opinion #27) is presented in full:

Opinion #27—Adopted January 23, 1980

Several concerns have been expressed to the Judicial Council by the Judicial Committee of the Union County Medical Society in regard to second surgical opinion programs.

The first issue involves the propriety of the second physician verifying that surgery is necessary and then performing that surgery at the request of the patient.

Assuming that the second surgeon has not acted improperly or exerted undue influence, the Council finds that there are no absolute barriers to prevent the second surgeon from performing the surgery. Freedom of choice of the patient along with trust implicit in the physician-patient relationship are controlling factors. The second surgeon does, however, have an ethical obligation to notify the referring surgeon that he will be performing the surgery at the patient's request.

The next issue involves the situation where the second physician, by attitude or conversation, implies that he is better qualified than the initial physician or that the patient has thus far not been properly treated.

The Council finds that such conduct would be the patent solicitation of patients, which is clearly unethical and potentially violates **N.J.A.C. 13.35-6.13** which prohibits solicitation of patients and claims of professional superiority.

It is the Council's experience that the most frequent complaint concerns fees or the misunderstanding of what was to be expected in the treatment of a patient. Wherever possible, it would seem wise to have a clear understanding between physician and patient regarding these considerations before treatment is undertaken.

The Council takes this opportunity to emphasize that decisions of judicial committees of component societies are binding upon all members. The judicial committee of each component society, in the enforcement of its findings duly arrived at, has the power to censure, suspend, or expel any member of its society for just cause.

Reference Committee felt that the section on "Ethical Procedures In Second Surgical Opinions" inadequately deals with these complex problems. The House referred the report back to the Judicial Council for further deliberation.

Executive Director

Vincent A. Maressa, Lawrenceville

(Reference Committee "A")

Several new programs and services have been added to Society benefits while some existing areas have been expanded.

LIABILITY CONTROL

Staff within this department has been increased and seven major projects are under way, with several others in planning. Doctor George's report will provide you with a more descriptive analysis.

PUBLIC AFFAIRS AND MEDICAL EDUCATION

The public relations program continues to be expanded and upgraded and has received several media awards for the quality of its programming. Our consulting firm, Paolin and Sweeney, has been contacted by other professional societies to structure similar programs for them. Two of their new accounts are the New Jersey State Bar Association and the New Jersey Dental Association.

We have instituted a visitation program with the presidents of component societies, specialty societies, and hospital medical staffs. Mr. Johnson has met with 26 physician officers in this regard through February, 1980.

In the medical education field, we have surveyed and accredited more hospitals proportionately than any other state, with the exception of Connecticut. Numerically, we stand fourth on a nationwide basis.

MEDICAL SERVICES AND INSURANCE AFFAIRS

This area of activity continues to grow with the Committee on Medicaid and the Council on Medical Services having very productive years. Mr. Lucci and his staff are responsible for administering to the needs of about 30 councils and committees. In addition to the above, major areas of activity have been the eye health screening program, hearing, emergency medicine, health planning, impaired physicians, alcohol and drug abuse, mental health, public health, maternal and child health, and membership inquiry and complaint.

FINANCIAL AND ADMINISTRATIVE SERVICES

The addition of Mr. Arthur White in July of 1979 to direct this department has greatly enhanced our capability. All finances are fully invested and well managed. Our printing, administrative, and record-keeping systems have been substantially upgraded.

The New Jersey State Medical Underwriters' office complex is scheduled for occupancy in the Fall of 1980. The Academy of Medicine of New Jersey and the New Jersey Foundation for Health Care Evaluation are now in place in our headquarters.

NEGOTIATIONS

This newly developed service is still in the formative stage. Our first formal case is scheduled for April, 1980.

PREPAID LEGAL SERVICES

Steven I. Kern, Esq., has agreed to offer to MSNJ members a very inexpensive legal services plan that will concentrate on the informal hearing process conducted by the Attorney General and the State Board of Medical Examiners.

A mailing on this topic was sent to all members in March, 1980. If you haven't enrolled, we sincerely suggest you consider doing so.

SUPREME COURT SUBPANELS (R. 4:21)

The new panel system developed by the Society and the State Supreme Court Committee on Relations with the Medical Profession has been an outstanding success. Over 90 cases have been heard in the first ten months of operation.

A major change has been effected in that physicians with an active open file are no longer routinely disqualified from sitting on panels.

The Rule 4:21 Judges and the Administrative Office of the Courts are pleased with the progress being made.

Our special appreciation is extended to those physicians who have volunteered to serve.

STAFF-BOARD RELATIONSHIPS

During the past 16 months, the Society has undergone significant change. We have moved into a new office complex which is without comparison in the state association field, and, at the same time, have had a major staff reorganization. The Board of Trustees and the active council and committee members have been most supportive and understanding. Staff performance (I am, indeed, prejudiced) has been outstanding, especially when you consider that they must tolerate my direction and guidance—or misguidance—as the case may be!

Filed in accordance with the recommendation of the Reference Committee.

Credentials

Arthur Bernstein, M.D., Chairman, East Orange

(Reference Committee "A")

The Committee on Credentials reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The following statistical breakdown reflects the Committee's activities during the period March 1, 1979 to February 29, 1980.

Received:	**Associate*	*Active*	*Osteo-paths*	*Grand Total*
*Interns	0			
*Residents	0			
Grand Total	0	400	12	412

Reviewed and found:	**Associate*	*Active*	*Osteo-paths*	*Grand Total*
(A) Satisfactory				
*Interns	0			
*Residents	0			
Sub Total	0	360	11	371
(B) Unsatisfactory	0	0	0	0
Pending:				
*Interns	0			
*Residents	0			
	0	22	0	22
Withdrew:				
*Interns	0			
*Residents	0			
	0	18	1	19
Grand Total	0	400	12	412

*Associate membership (non-licensed in New Jersey) designates Interns and Residents.

The Committee extends appreciation to the directors and the secretaries of components societies, and to those who assist them, as well as to the County Credentials Committees, for their cooperation in processing membership applications. It would be especially helpful to the Credentials Committee of MSNJ if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application form. This procedure will help insure more accurate and speedy evaluation of credentials. The chairman wishes to thank his Committee members and the MSNJ staff for their diligence and cooperation.

Filed in accordance with the recommendation of the Reference Committee.

Long Range Planning and Development

William J. D'Elia, M.D., Chairman, Spring Lake

(Reference Committee "A")

During the past year, the Committee met on three occasions. Topics considered by our Committee included:

MEDICAL SOCIETY OF NEW JERSEY STUDENT ASSOCIATION

In response to a referral from the Board, the question of whether or not voting privileges on the Board of Trustees and in the House of Delegates should be extended to members of the Medical Society of New Jersey Student Association was considered. During the deliberations, it was apparent that MSNJ should adopt the concept of encouraging medical students to become regular members of the Society and incorporate them into the composition of the House of Delegates. It was the consensus of the Committee that slotted representation for medical students on the Board would be impractical without using slotted representation for other segments within the Society. Recommendations made by the Committee pertaining to members of MSNJSA serving as voting delegates at the sessions of the House of Delegates were approved by the Board and forwarded to the Standing Committee on Revision of Constitution and Bylaws for preparation of the necessary bylaw amendments. The Committee on Constitution and Bylaws since has advised the Board of Trustees that granting medical students a direct seat in the House of Delegates, as opposed to being members of a county society, would require a charter change. The change currently being suggested for specialty societies would suffice and the proper wording could be incorporated in amended Bylaws.

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

The Committee reviewed a referral from the Board containing a suggestion by the President that the composition of the House of Delegates be evaluated. Recognizing the need for individual voices to be heard within the House of Delegates to represent specialty societies, a recommendation was made to the Board that each specialty organization designate a delegate from one of the component societies who is a member of the respective specialty group to represent their views in the House of Delegates.

The Board approved the recommendation, with the amendment that the specialty society shall be designated in some visible manner on the badge of the delegate so named.

In view of the desire of the specialty societies to have their own representation in the House, rather than to appoint a delegate to act as a spokesman for the specialty, further consideration was given to the issue. The composition of the House is restricted by charter to elected delegates from counties. Therefore, an amendment to the corporate charter, through a request of the New Jersey Legislature, would be required before specialty society representatives can serve in the capacity of delegates. It was concluded that the specialty societies should be allowed representation in the House of

Delegates to permit individuals to speak as representatives of their specialties, and a recommendation was made to the Board to accommodate a number of seats (not to exceed 20).

The Board was not in favor of limiting the number of seats to an arbitrary figure and approved a request to effect a charter change to allow representatives of national certified specialties to serve in the capacity of delegates in the House, with representation not to exceed one delegate for each specialty. A resolution to this effect will be introduced by the Board of Trustees.

REAPPORTIONMENT OF THE HOUSE OF DELEGATES

At the direction of the Board, the Committee also reviewed the current ratio of delegates serving in the House and agreed that the current number of delegates appears to be unwieldy. The determination to reduce the number of delegates was reached on the basis of the need for a more efficient meeting of the House, and it was felt that a reduction in the size of the House would be conducive to achieving a more thorough and comprehensive presentation of issues. A recommendation was made that the Board of Trustees approve the concept of limiting the number of elected delegates in the House to 300, using a ratio of one (1) delegate per thirty-one (31) members, with the proviso that each component society will be entitled to at least three (3) delegates.

The Board voted in favor of the concept and will introduce a resolution to that effect at the 1980 Annual Meeting.

STATE BOARD OF MEDICAL EXAMINERS

The Committee also included in its study of the organizational structure of the Society the relationship between the Board of Trustees and the State Board of Medical Examiners. The Committee noted that the Board of Trustees has taken steps to effect a better rapport with the State Board. For the present, the Committee suggested that the Society should continue assigning the President-Elect as the official liaison to the State Board, assigning a rotating trustee to attend the monthly meetings of the State Board, and assigning a staff member to attend the monthly meetings. It also was suggested that meetings should be held periodically with the State Board to keep the avenues of communication open.

Filed in accordance with the recommendation of the Reference Committee.

(AMA) Ad Hoc Committee on Principles of Medical Ethics

James S. Todd, M.D., Chairman, Ridgewood

(Reference Committee "A")

A final report of the Ad Hoc Committee on the Principles of Medical Ethics was submitted to the AMA House of Delegates at the 1979 Annual Meeting. After adopting Recommendation 3 of the report, the House directed that the remainder of the report be distributed to State Medical Associations, Component Medical Societies, and Specialty Societies for study and consideration by their respective Houses of Delegates, for possible revision by the Committee. The House also asked for a progress report at the 1979 Interim Meeting and a final report at the 1980 Annual Meeting.

Pursuant to the action of the House, the Committee's Final Report is here presented. It is believed that the Committee's Interim Report also would be helpful in providing more background information, and that report also is included.

These reports and proposed principles are the result of extensive study and testimony directed at achieving the appropriate ethical stance of the medical profession in contemporary society. In the study of those documents it should be recognized that no principle stands by itself, but all are interrelated and it is the aggregate influence that applies in defining an ethical response to any given situation.

It is requested that these documents be submitted to your House of Delegates or corresponding policy-making body for the widest possible distribution and response. In order to amplify and explain this proposed revision in the Principles of Medical Ethics, Committee members are available to address this important topic. Travel expenses for this purpose, however, must be paid by the host society.

We trust that your society will give careful consideration to these reports. Please submit your conclusions and recommendations to the Committee at the AMA headquarters. If you require additional information or wish to invite a Committee member to your meeting, contact Mr. Neil Sutherland, Special Assistant to the Executive Vice President.

INTERIM REPORT AND RECOMMENDATIONS

Introduction—

The Ad Hoc Committee on the Principles of Medical Ethics was established as a special committee of the House of Delegates on recommendation of the Judicial Council and with concurrence of the House during the 1978 Annual Meeting. In acting on this recommendation, the Speakers appointed the following physicians to serve on the Ad Hoc Committee:

James S. Todd, M.D., Chairman
H. Thomas Ballantine, Jr., M.D.
Amos P. Bratrude, M.D.
John J. Coury, Jr., M.D.
Jean F. Crum, M.D.
Henrietta Herbolsheimer, M.D.
Joseph T. Painter, M.D.
Carroll L. Witten, M.D.

During the 1977 Interim Meeting of the House, the Judicial Council introduced Report A—"AMA Principles of Medical Ethics," which offered revised Principles for consideration. The stated intent of the revisions was to clarify and update the language of the Principles, including elimina-

tion of the masculine and feminine pronouns, and also to reach a proper stand between professional standards and the anti-trust laws which now are being applied against the professions. The Principles had not been revised since 1957. In keeping with the provisions of the AMA Bylaws that require proposed amendments to the Principles to be held over for one meeting of the House before being enacted, the House deferred action on Report A until the 1978 Annual Meeting.

Following extensive debate in reference committee and on the floor of the House, the House voted to defer action on Report A (I-77); adopted Report A (A-78) of the Judicial Council, which recommended the establishment of the Ad Hoc Committee; and referred Report II of the Board of Trustees—"Principles of Medical Ethics" and Resolutions 36, 60, 71, 92, 121, 124, 133, and 152, all of which related to the Principles, to the Ad Hoc Committee. The first resolve of Resolution 59 was amended and referred to the Ad Hoc Committee. The second resolve of Resolution 59 also was referred to the Ad Hoc Committee.

The action taken by the House is best summarized by the following excerpt from Report A of the Judicial Council (A-78):

"Given the desire of the Judicial Council for a new version of the Principles to be widely accepted and accurately understood and given the concerns expressed in resolutions presently before the House, the Judicial Council recommends that a special committee of the House be appointed to consider the revision of the Principles further. To assure that this special committee is broad-based, the Council recommends that it consist of appropriate representatives from the House of Delegates and the Board of Trustees and that it meet with the Judicial Council to study this matter further. Although this will delay consideration of the revision of the Principles, this appears unavoidable under the circumstances.

"Accordingly, the Judicial Council recommends that the proposed revision of the AMA Principles of Medical Ethics, Judicial Council Report *A* (I-77), be reintroduced at this convention and that a special committee of the House be created to study this matter and report back to the House at the next meeting of the House."

While the Ad Hoc Committee understands that the emphasis of its charge was on the review of the current Principles of Medical Ethics and the proposed revision, it believed that this review warranted a more comprehensive study of the role of ethics in our society. Its study to date has considered what type of ethical code is appropriate for the American Medical Association and the nation's physicians, rather than a limited review of the two versions of the Principles pending before the House.

Activities to Date—

In July, 1978, the Chairman of the Ad Hoc Committee asked that state, metropolitan, county, and specialty organizations be invited to submit comments on the proposed revisions to the Principles. A total of 47 responses was received and examined. As provided under House policy, the sponsors of the nine referred resolutions also were contacted and provided an opportunity to submit personal testimony. Representatives of the American College of Radiology appeared later to present oral testimony and also submitted a written statement. Representatives of the other sponsors responded in writing to reconfirm their previous positions and/or to provide additional information.

The Ad Hoc Committee has held three meetings prior to the 1978 Interim Meeting. The first of these, on September 9-10, was to discuss the general function and purpose of medical ethics, and a portion of the first meeting included a presentation by Professor James Gustavson of the University of Chicago. Two representatives of the American College of Radiology also met with the Ad Hoc Committee, and representatives of the AMA's Office of the General Counsel made a presentation at the Ad Hoc Committee's request. All of the referred materials and the comments that had been received were reviewed.

The second meeting, on October 7-8, included a meeting with representatives of the Judicial Council. The Ad Hoc Committee later discussed the elements that should be included in this report.

A third meeting was held on October 28 to finalize this report.

All of these activities were oriented to having the Ad Hoc Committee better understand the role of ethics in our society and the issues pending before the House that related to ethics, and to giving all interested parties an opportunity for comment.

The AMA and Medical Ethics—

In its deliberations, the Ad Hoc Committee was impressed by the manner in which ethics have been developed and used throughout history. Ethics have been drawn from many areas, including law, human experience, customs, and in medicine's case, the concepts of scientific medicine. Ethics are generated from human experience and are influenced by an analysis of the circumstances in which we are to act and the appropriateness of the action to these circumstances. Ethics also can vary with types of civilizations and can change and evolve with the times. Ethics for a profession depend in large measure on the role of that profession.

In our society, ethical principles seem to have evolved into rules of conduct as individuals are perceived as being less virtuous and there is increased doubt about the reliability of the individual. The more precise the rule, the easier is adherence with a consequent reduction of accountability. Principles maximize discretionary powers, but place more individual responsibility for the consequences of action. Most briefly stated, ethics are meant to insure fitting response to circumstance. As time has passed, ethics have become more directly related to law.

The Principles of Medical Ethics have gone through a similar evolutionary process. The working of the Association's earliest Principles reflected the economic, legal, and sociological circumstances of the mid-nineteenth century. Prior to 1957, when the Principles were last revised, they included much of the detail that is now carried in the Opinions and Reports of the Judicial Council. The Judicial Council separated out the detailed interpretations so that they could be revised and updated to reflect the changing circumstances of medical practice, but the Ad Hoc Committee believes that a portion of the present Principles reflects economic guidelines and professional etiquette, rather than moral principles.

For example, Section 7 of the current Principles states that "In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interest of the patient."

The Ad Hoc Committee was unsure as to whether this language represented an ethical mandate or an economic

guideline, and it believes that additional study is necessary before commenting on a code of ethics appropriate to use by the AMA.

Basic Agreements of the Ad Hoc Committee—

With this introduction and background, the Ad Hoc Committee concluded that:

1. A code of ethics is desirable and necessary to provide guidance to physicians in the conduct of their practices.
2. The medical profession is no longer perceived as the sole guardian of public health.
3. Physicians need to be responsive to their patients, to their profession, to society, and to themselves as individuals without jeopardizing one at the expense of the other.
4. The body that generates a code of ethics should be distinct and separate from the body that interprets and enforces them.
5. The code of ethics should not make reference to gender.

Issues—

The present "Principles of Medical Ethics" include statements of etiquette and arbitrary rules of conduct as well as moral or ethical principles. Agreement on specific rules and the form of expression of the "Code" or "Principles" of Medical Ethics will be difficult to accomplish because of the many problems which immediately became apparent to the committee.

Among these are:

1. Will the current Principles of Medical Ethics or the proposed revision withstand scrutiny within the present public or legal climates?
2. What is the changing role of the medical profession?
3. What is the present relationship of physicians to limited licensed practitioners?
4. Is there a distinction between the roles of diagnostic and therapeutic specialists?
5. Is there a distinction of responsibilities between diagnostic and therapeutic specialists?
6. What is the appropriate stance regarding advertising and the solicitation of patients?
7. What is the relation of ethics to law and regulation?
8. What are the anti-trust implications of professional ethics?
9. Is individual responsibility being replaced by group responsibility in the profession?
10. Is there a need for rules in certain areas of etiquette and economics separate from ethics?

The Ad Hoc Committee hopes that the discussion of these points that will occur during the 1978 Interim Meeting will give it some indication of the attitudes of the members of the House.

Conclusion—

The committee has reached the conclusion that the Association should have a statement of Medical Ethics. The committee believes that this is a matter of utmost importance and deserves the best efforts of the Association. These Principles must be primarily for the benefit and protection of patients, yet clearly define the relationship of physicians to their colleagues and contemporary society. They also must be consistent with all applicable laws. They need to respond constructively to the physicians' relationships with growing numbers of persons who are not fully licensed to practice medicine and surgery in all its branches. Finally, they must consider the particular problems of the physician specialist, whose practice may or may not include continuity or comprehensiveness of care.

In view of the foregoing, the committee believes that it cannot recommend either that the present Principles of Medical Ethics be continued unchanged or that the proposed revisions be adopted. The committee believes that additional study is necessary before a final conclusion can be reached, and that other elements of the AMA should be involved in some portions of this additional study.

Recommendation—

The Ad Hoc Committee on the Principles of Medical Ethics recommends that it be authorized to continue its study of the Principles of Medical Ethics and the Reports and Resolutions referred to it during the 1978 Annual Meeting, and that it submit a final report for consideration by the House of Delegates during its 1979 Annual Meeting.

FINAL REPORT WITH RECOMMENDATIONS

Introduction—

During the 1977 Interim Meeting of the House of Delegates, the Judicial Council introduced Report A, "American Medical Association Principles of Medical Ethics," which offered revised Principles for consideration. The stated intent of the revision was to clarify and update the language, to reach a proper stance between professional principles and contemporary society and to eliminate any reference to gender. First adopted in 1847, Principles were revised during the 40's and most lately in 1957. The latest publication of the "Opinions and Reports" of the Judicial Council was issued in 1977, the first such revision since 1966.

Following debate in the Reference Committee on Amendments to Constitution and Bylaws and on the floor of the House, the House deferred action on the Revised Principles and approved the Judicial Council Report A (A-78) recommending "that a special committee of the House be appointed to consider the revision of the Principles further. To assure that this special committee is broad-based, the Council recommends that it consist of appropriate representatives from the House of Delegates and the Board of Trustees, and that it meet with the Judicial Council to study this matter further."

The Speakers of the House appointed the following to serve as an Ad Hoc Committee:

James S. Todd, M.D., Chairman
H. Thomas Ballantine, Jr., M.D.
Amos P. Bratrude, M.D.
John J. Coury, Jr., M.D.
Jean F. Crum, M.D.
Henrietta Herbolsheimer, M.D.
Joseph T. Painter, M.D.
Carroll L. Witten, M.D.

This Ad Hoc Committee presented an initial report to the House of Delegates at the 1978 Interim Meeting. In that report the Committee detailed its activities and indicated that while the emphasis of its charge was on the review of the current Principles of Medical Ethics and the revision proposed by the Judicial Council (I-77), the Committee believed that such a review warranted a more comprehensive study of the evolution of ethics in society, the role of ethics for a profession and the consequences of ethical statements vis-à-vis society and law.

In its first report, the Committee did, however, submit the following conclusions to the House:

1. A code of ethics is desirable and necessary to provide guidance during the conduct of a physician's practice.

2. The medical profession is no longer perceived as the sole guardian of the public health, and consequently the traditional paternalism of the profession is in conflict with society.

3. Physicians need to be responsive to their patients, to their profession, to society, and to themselves as individuals without emphasizing one at the expense of the others.

4. The body which generates a code of ethics should be distinct and separate from the body which interprets and enforces that code.

5. A code of ethics should not make reference to gender.

6. Neither the present Principles of Medical Ethics nor the revised version could be recommended as appropriately articulating the proper ethical stance for the profession.

7. The Committee should continue its study, and make a final report to the House during the 1979 Annual Meeting.

With the acceptance of this report by the House of Delegates, the Ad Hoc Committee believed that the House expected the development of a new code of medical ethics based on firm principles and consonant with the demands of contemporary society. Although fully cognizant that the current Principles were considered adequate by some members of the Association, the Committee did not feel that its reponsibility would be discharged properly without providing the House with a revision which would not only respond to contemporary changes, but which also would more fully express a physician's dedication to high ideals.

Consequently, state, metropolitan and specialty organizations, as well as sponsors of resolutions, were once again asked to submit comments and proposals regarding what a code of ethics for the profession should contain. Issues pertaining to interpretation were specifically excluded since the Committee firmly established that those who generate codes should not interpret them.

Twenty reponses were received; five from individuals, five from specialty societies, and ten from state or county medical societies. Additionally, oral testimony was received from the Judicial Council, the American Psychiatric Association, the Resident Physician Section, the American College of Radiology, the American College of Surgeons, the American Academy of Orthopaedic Surgeons, The Medical Association of Georgia, and W. Dan Jordan, M.D., representing Frank A. Rogers, M.D.

The Ad Hoc Committee held four meetings since the 1978 Interim Meeting. The first, on January 5-6, was a meeting with the Judicial Council and a careful review of the written material submitted to the Committee since its formation. The second meeting, March 24-25, was devoted to receiving oral testimony and to considering what should be the form for the report and principles. A third meeting was held April 28-29, during which the report and principles were drafted. A final meeting was held on June 24 to finalize this report. The goal of these deliberations was to develop a new version of the Principles of Medical Ethics which, while addressing classical areas of ethical responsibility, would also be contemporary enough to preserve the position of medicine among the professions.

Ethical Philosophy—

As a consequence of its study, the Ad Hoc Committee has concluded that moral principles are standards of conduct applicable to all segments of society, while ethical principles are standards of conduct in accord with the moral standards of a society, but particularly applicable to a special segment of that society. Medical ethics are, therefore, a specific application of the universal norms of moral behavior. It should not be assumed that there is a special type of ethics appropriate solely to our own profession. Ethics for a profession depend upon the role of that profession, and, as in medicine, when the role expands, ambiguity and uncertainty appear. Traditionally, ethics evolve from human experience and define what one ought to do. As human experience expands and changes, so does the need for study of ethical behavior.

A code of ethics sets the limits beyond which behavior will be unacceptable, and in general addresses areas not defined by law. In many instances ethics will establish standards of greater virtue than law, and while ethical behavior requires conformance to law, it also mandates lawfully conducted action to change those provisions felt to be morally inferior or detrimental. If only an appeal to individual conscience were allowed, chaos would result. The professional must work within the constraints and expectations set by those who commission his work.

The shifting sands of society preclude longstanding adherence to ethical principles without reevaluation and restatement into forms appropriate to the times. No professional organization has adhered immutably to unchanging codes, and the American Medical Association is no exception. Ethical changes cannot be settled solely by rational discussions, but rather as a result of the realistic evaluation of human experience.

Ethics were never intended to be laws, but rather standards by which one may be measured. Ethics are broad and lofty ideals which permit individual discretion counterbalanced by individual accountability. Rules, on the other hand, restrict individual discretion, and by close adherence, reduce accountability. In a profession where the individual is dominant, as in medicine, latitude for individual discretion and accountability must be provided. A hallmark of a professional is the willingness of the individual to assume personal responsibility for professional activities.

Any restatement of ethical principles should not be looked upon as a change in policy or a lowering of standards, but rather as a refinement of those principles to a level where they have greater contemporary meaning. Ethical behavior is behavior that is appropriate and fitting in particular circumstances guided by more universal norms. The specific mandate does not change, but its application does. Physicians will be in an increasingly awkward position if they hold to the traditional commitment that their only concern is to the patient. Society is demanding more and the need for change should not be ignored. Ethics as statements of virtuous conduct have been evolutionary in development, and that evolution inevitably will continue as new problems and attitudes develop. Professionals must distinguish between a profession and a function. The function truly may be eternal, but a profession is temporal and must respond to change if it is to survive. The profession does not exist for itself, it exists for a purpose, and increasingly that purpose will be defined by society. Failing this accommodation, the profession will wither as external pressures mount.

Application to the American Medical Association—

The American people look to the medical profession and the American Medical Association to establish standards for professional action in response to specific problems. Physi-

cians look to the American Medical Association for guidance, information, coordination and representation. To fulfill these expectations the Association must have a strong set of Ethical Principles as a statement of what the profession and its individual members stand for, and emphasize how those members are dedicated to public service without referring to specific means or mechanisms. In any given situation, instead of utilizing a single principle for guidance, the aggregate influence of all the Principles should apply in determining appropriate action.

Paternalism by the profession is no longer appropriate, since no longer is the profession perceived by the public as the sole guardian of the public's health. Physicians must not fall prey to believing that all health benefits come from areas of their own experience and scientific validity alone. Conversely, however, where science has shown a specific practice to be detrimental, physicians must be vigorous in denouncing it.

A difficulty of any profession is that, while individuals differ as much as humans can, professionals are expected to act in a standard manner. The Ad Hoc Committee has tried to find the appropriate ethical position of the profession recognizing the shifting expectations of society and the influence they have on the profession.

Issues Requiring Further Consideration—

During its deliberations, the Ad Hoc Committee perceived issues beyond its purview deserving further study and consideration by the House of Delegates.

1. Should this proposed version of the Principles of Medical Ethics be adopted, the Opinions and Reports of the Judicial Council then may not be totally appropriate. The Ad Hoc Committee is of the opinion that, if these Principles are adopted, it is essential that the Opinions and Reports should be reviewed and perhaps rewritten after further debate of the issues with presentations before the Judicial Council by interested parties. To dispel any remaining assumptions that the House of Delegates can change an opinion of the Judicial Council, the Ad Hoc Committee would call attention to the summary in the report of the Reference committee on Amendments to Constitution and Bylaws (I-78), page 2:

"The 1977 edition of Judicial Council Opinions and Reports is presently in effect.

"Under the Bylaws, Opinions and Reports of the Judicial Council interpreting the AMA Principles of Medical Ethics need not be submitted to the House of Delegates for approval. The Bylaws confer upon the Judicial Council final authority to interpret the American Medical Association Principles of Medical Ethics.

"The Judicial Council can modify or amend its opinions and reports at any time . . . the following statement appears on Page 1 of the 1977 edition of Judicial Council Opinions and Reports:

"Opinions and Reports of the Judicial Council remains a basic compilation of interpretations, opinions and statements of the American Medical Association Judicial Council which may be expanded, contracted, or modified from time to time to meet changing conditions of medical practice."

As was done in the Substitute Resolution for Resolutions 16, 50 and 106 (I-78), the House may, however, request the Judicial Council to reconsider its opinions.

2. With the emergence of bioethical issues such as the technology of genetic contol, recombinant DNA, and controlled fertility along with the changes in society's moral position, the medical profession can expect to face many ethical problems in the future. The Ad Hoc Committee believes a mechanism should be developed for monitoring, periodically reviewing and anticipating the ethical stances to be taken by the profession.

3. In order to establish the House of Delegates clearly as the body which generates the Principles of Medical Ethics, the Bylaws need to be amended by deleting "the establishment of principles and" from Chapter XIII, Section 4A, 2d. (6.4011 decimalized version).

4. Extensive testimony was heard regarding a perceived change in American Medical Association policy regarding chiropractic. In 1966 (C-66), the House of Delegates approved Report E of the Board of Trustees which spoke directly to the status of chiropractic. Although modifying statements have been adopted, no subsequent action has been found which would clearly change that position. In the opinion of the Ad Hoc Committee, the current position of the Association relative to chiropractic needs to be clarified.

5. During the discussion of physician responsibility to patients, it soon became apparent that there was a subtle difference in the doctor-patient relationship between the physician acting in a purely diagnostic role, and the physician who provides continuing care. The latter physician has an ongoing relationship and responsibility to the patient for as long as the therapy or its effects continue. The physician serving only a diagnostic role appears to have discharged responsibility to the patient once a competent report is returned to the referring entity.

The Ad Hoc Committee feels that these apparently differing responsibilities should be studied and a report submitted to the House on the appropriate role of the primarily diagnostic and the therapeutic physician.

Conclusions and Recommendations—

The Committee is of the firm opinion that the Association should have a strong, broad set of Ethical Principles, maximizing individual discretion and accountability while at the same time informing the public of an uncompromising attitude toward honorable behavior within the profession. While primarily for the benefit and protection of patients, such principles must clearly embrace the relationships of physicians to their colleagues and to contemporary society. No one should expect any Principles of Medical Ethics to stand unchanged forever, but by responding in a consistent fashion to a rapidly expanding and changing society, the American Medical Association can be worthy of the moment and the future.

With this goal in view, the Ad Hoc Committee presents for final action at the 1979 Interim Meeting the following version of the Principles of Medical Ethics:

PRINCIPLES OF MEDICAL ETHICS

Preamble: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of those whom it serves. As a member of this profession, a physician must recognize responsibilities to society, to patients, to other health professionals and to self. The following principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing medically competent service with compassion and respect for human dignity.

II. A physician shall uphold the honor of the profession

by dealing honestly with patients and colleagues and striving to expose those physicians deficient in character, competence, or who engage in fraud or deception.

III. A physician shall respect the law, and also recognize a responsibility to seek changes in those requirements contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to the public, and utilize the talents of other health professionals when indicated.

VI. A physician, except in emergencies, shall be free to choose whom to serve, with whom to associate, and the environment in which to provide services consistent with appropriate patient care.

VII. A physician, as a member of society, shall recognize a responsibility to participate in activities contributing to an improved community.

Annotations to the Principles of Medical Ethics—(not to be an integral part of the Principles)

The preamble and seven principles were developed after a thorough assessment of the prime areas of physician concern within society and the profession. They represent a logical continuum beginning with a presumption of broad responsibility, with subsequent specific statements regarding discipline, society, due process, implementation of function, reserved rights, and independent responsibility as a citizen. No one Principle can stand alone or be individually applied to a situation. In all instances, it is the conglomerate intent and influence of the Principles which shall measure ethical behavior for the physician. Interpretation and application of these Principles are the prerogatives of the Judicial Council.

Preamble: This language establishes broad areas of responsibilities for all physicians, and reaffirms the belief that ethical standards are for the benefit of the patient. To allow for maximal individual discretion and accountability, these statements are clearly guidelines open to interpretation and universal application.

I. A concise statement of mission emphasizing the magnitude of a physician's commitment, and how it shall be met.

II. This wording is a clear mandate for self-discipline, calling on the precepts of fairness and honesty toward all. The deceitful are to be exposed, the impaired helped, and the unscientific educated.

III. Society should expect obedience to laws properly enacted, but the dedication of a physician requires lawful disagreement and attempts at modification of those laws inimical to sound patient care or contrary to accepted moral behavior.

IV. Due process is constitutionally guaranteed. No one has, or should have, the ability to abridge the legally given rights of another. Similarly the professional relationship is predicated on trust, and the confidentiality of this relationship, within the constraints of the law, must be assured.

V. Effective implementation of a physician's mission depends upon the application of sound scientific concepts, the ability of the public to make intelligent health choices, both as to procedure and person, and the liberal use of consultation with other health professions as may be indicated.

VI. Within the framework of these Principles, the physician is entitled to certain rights which should not be denied if individual talents are to be developed to the fullest. Freedom of choice both by physician and patient is essential.

VII. Citizens should participate in community and societal affairs. By virtue of special training, a physician, as a citizen, may have additional value and should recognize that possibility. Whether to exercise that citizen's responsibility always has been and should remain an individual decision.

Recommendation 1

That this proposed version of the Principles of Medical Ethics be placed before this House now for final action at the Interim Meeting in December 1979.

Recommendation 2

That there should be developed by the Board of Trustees a mechanism within the House of Delegates for the ongoing evaluation and modification of ethical positions as may be required from time to time.

Recommendation 3

That the Bylaws be amended by deleting the words "the establishment of principles and" from Chapter XIII, Section A, subsection 2d (6.4011 decimalized version).

Recommendation 4

That the Judicial Council be asked to view their Opinions and Reports in consonance with this revision of the Principles of Medical Ethics, if adopted.

Recommendation 5

That this report be accepted in lieu of Resolutions 36, 60, 71, 92, 121, 124, 133 and 152 and Report II of the Board of Trustees (A-78), as well as Resolutions 12, 13, 24, 49, 53, 70, 88, 99 and 105 (I-78) and Report A of the Judicial Council (I-77).

(AMA) House Action—July 1979

Recommendation 3 **adopted and referred** to Council on Constitution and Bylaws for report at the 1979 Interim Meeting

Current AMA Principles of Medical Ethics

Preamble. These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1. The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man.

Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2. Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3. A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4. The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and

accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5. A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6. A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7. In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interest of the patient.

Section 8. A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9. A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10. The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and well-being of the individual and the community.

Filed in accordance with the recommendation of the Reference Committee.
(See Substitute Resolution #19, page 29)

Resolutions

#1

Introduced by: **Hudson County Medical Society**

Subject: **DEFINITION OF "POLICY"**

Referred to: **Reference Committee "A"**

Whereas, we live in an admittedly changing world; and

Whereas, such changes may be for better or for worse; and

Whereas, we physicians, as community leaders, should be in the forefront of supporting positive changes and opposing those proposals whose long-term effects will be detrimental; and

Whereas, opposition to further governmental intrusion is vital if we are to preserve the private practice of medicine; and

Whereas, our rejection of proposals such as federal catastrophic health insurance constitutes a policy of opposition; and

Whereas, declaring publicly that we have "no policy" or "no position" nullifies and falsely refutes the action of the House of Delegates and offers the public a choice of judging us either timid or stupid; now therefore be it

~~RESOLVED, that in the future, unless specifically modified, rejection of a proposal by the House of Delegates shall be interpreted as objection and opposition to that proposal; and be it further~~

~~RESOLVED, that such objection and opposition extend to any more intrusive or more objectionable proposals regarding said subject.~~

Withdrawn by the sponsor.

#7

Introduced by: **Board of Trustees**

Subject: **REAPPORTIONMENT OF HOUSE OF DELEGATES**

Referred to: **Reference Committee "A"**

Whereas, several committees of the Medical Society of New Jersey have studied the size of the House of Delegates of MSNJ; and

Whereas, these committees have found that a reduction in the size of the House would facilitate a more efficient, thorough, and comprehensive presentation of issues; now therefore be it

RESOLVED, that the Committee on Revision of Constitution and Bylaws be instructed to prepare amendments to the Bylaws, limiting the number of elected delegates to 300, with each component society entitled to at least three delegates.

Rejected in accordance with the recommendation of the Reference Committee.

#8

Introduced by: **Board of Trustees**

Subject: **~~SPECIALTY SOCIETY/MEDICAL STUDENT~~ REPRESENTATION IN THE HOUSE OF DELEGATES**

Referred to: **Reference Committee "A"**

Whereas, the issue of specialty society and medical student representation in the House of Delegates has been urged by several committees of the Medical Society of New Jersey; and

Whereas, it will be necessary to amend both the corporate charter of MSNJ and the Society's Constitution and Bylaws; and

Whereas, the legislative charter must be amended before the Constitution and Bylaws can be amended; now therefore be it

RESOLVED, that the House of Delegates authorize the Board of Trustees to petition the New Jersey Legislature to amend the corporate charter to recognize the right of the Medical Society of New Jersey to ~~include specialty and student representatives in the House of Delegates~~, **define the representation in its House of Delegates.**

Adopted as amended by the House of Delegates.

#10

Introduced by: **Frank J. Primich, M.D., Delegate Hudson County**

Subject: **OPPOSITION TO ANY TYPE OF FEDERALLY CONTROLLED HEALTH INSURANCE**

Referred to: **Reference Committee "A"**

Whereas, the 1979 House of Delegates voted against the "minimal" Federal Catastrophic Health Insurance plan acceptable to the AMA; and

Whereas, numerous variations on the catastrophic theme are again being considered; and

Whereas, any of these proposals can be readily converted through bureaucratic interpretation and implementation into a Kennedy-type form of socialized medicine; now therefore be it

RESOLVED, that the Medical Society of New Jersey oppose

any type of federally controlled national health insurance; and be it further

RESOLVED, that, if accepted, this resolution shall indicate MSNJ's policy to be in opposition to any further governmental intrusion into the provision of health care.

Rejected in accordance with the recommendation of the Reference Committee.

#11

Introduced by: **Hudson County Medical Society**

Subject: **STANDARDS FOR ~~NATIONAL~~ HEALTH INSURANCE COVERAGE**

Referred to: **Reference Committee "A"**

Whereas, Resolution #62 was adopted by the AMA House of Delegates in December, 1978; and

Whereas, any changes to improve health care should be built upon the strengths of the existing pluralistic system; and

Whereas, in the formulation of any changes in the medical care delivery system it is important that the voice of the medical profession be heard; now therefore be it

RESOLVED, that the Medical Society of New Jersey be on record that any modifications of the health insurance system embody the following principles:

1. All health insurance policies sold in the United States be required to provide adequate benefits conforming at the least to minimum standards as defined by the AMA.
2. A simple system of uniform benefits be provided for persons who cannot afford to purchase their own health insurance, by federal government payment of premiums to insurers, in part or in whole as appropriate.
3. A nationwide program be provided by the private insurance industry to make available catastrophic insurance coverage to counter the tragic economic impact of a catastrophic illness on an individual or family.
4. Appropriate cost-sharing by the patient or the employer (through deductibles and coinsurance) be a part of basic and catastrophic coverage.
5. Freedom of choice by physicians and patients be preserved.
6. Programs developed in accordance with these principles be administered at state level through the use of nongovernmental insurance mechanisms; and be it further

RESOLVED, that the Medical Society of New Jersey continue to oppose any federally-controlled or federally-administered ~~national~~ health insurance; and be it further

RESOLVED, that this resolution be forwarded to the American Medical Association.

Adopted in accordance with the recommendation of the Reference Committee, with minor editorial changes.

#12

Introduced by: **Essex County Medical Society**

Subject: **ADOPTION OF AMA CONCEPTS AND POLICIES ON NATIONAL HEALTH INSURANCE AND CATASTROPHIC HEALTH INSURANCE**

Referred to: **Reference Committee "A"**

Whereas, policy on modifications to our present health care system has been outlined at a recent AMA House of Delegates meeting; now therefore be it

RESOLVED, that the Medical Society of New Jersey adopt in principle the following concepts and policies on national health insurance and catastrophic health insurance espoused by the AMA House of Delegates:

1. Requiring minimum standards of adequate benefits in all health insurance policies sold in the United States with appropriate deductible and coinsurance.
2. A simple system of uniform benefits provided by the federal, state, and local governments for those indiviuals who are unfortunate enough (through no fault of their own, e.g., age, disability, financial hardship, etc.) not to be able to provide for their own medical care.
3. A nationwide program by the private industry of America (and government if necessary for reinsurance) to make available catastrophic insurance coverage for those illnesses

and individuals where the economic impact of a catastrophic illness could be tragic. All catastrophic coverage should have an appropriate deductible and coinsurance to make it economically feasible and to avoid abuse.

4. A program developed pursuant to these principles should be administered at the state level with national standardization through federal guidelines.

Rejected in accordance with the recommendation of the Reference Committee.

#14

Introduced by: **Essex County Medical Society**

Subject: **THE PRACTICE OF CHIROPRACTIC**

Referred to: **Reference Committee "A"**

Whereas, the House of Delegates of the American Medical Association has changed its previous position on chiropractic; and

Whereas, our Code of Ethics requires the medical profession to speak out against unwarranted and potentially harmful modes of treatment of disease; now therefore be it

RESOLVED, that our delegates note that the California Medical Association has voted to revise its position as follows:

"CMA has emphasized, repeatedly, that the diagnosis and treatment of disease by practitioners attributing all such ailments to misalignment of the spinal vertebrae is a hazard to health.

"A patient who relies on such practitioners in the treatment of ailments such as essential hypertension, heart disease, stroke, cancer, diabetes, and infections may delay proper medical care until serious and irreversible damage occurs.

"CMA strongly disapproves of the inclusion of such inappropriate treatment in any health care payment program"; and be it further

RESOLVED, that the House of Delegates of the Medical Society of New Jersey accept the CMA revision concerning its position on chiropractic in keeping with our earnest desire to inform and protect the people of the State of New Jersey and so inform the House of Delegates of the AMA.

The following Substitute Resolution #14 was recommended by the Reference Committee.

Substitute #14

Subject: **PRACTICE OF CHIROPRACTIC**

RESOLVED, that the House of Delegates affirm the following statement of the AMA regarding chiropractic:

The American Medical Association knows of no scientific evidence to support spinal manipulation and adjustment as appropriate treatment for human ailments such as essential hypertension, heart disease, stroke, cancer, diabetes, and infections. Accordingly, the Association will continue to warn the public of the hazards to health in entrusting the diagnosis and treatment of such conditions to practitioners who rely upon the theory that all disease is caused by misalignment of spinal vertebrae and can be cured by manual manipulation and adjustment of the spine.

Adopted in accordance with the recommendation of the Reference Committee.

#17

Introduced by: **Bergen County Medical Society**

Subject: **MANDATORY AMA MEMBERSHIP**

Referred to: **Reference Committee "A"**

Whereas, the impact of pressure from various public and private bodies is increasingly encroaching upon the private practice of medicine; and

Whereas, the need for a unified organization on the part of all physicians is essential; and

Whereas, the American Medical Association is the logical organization that cuts across all local and specialty societies to speak for organized medicine; and

Whereas, the American Medical Association increases its political "clout" in direct proportion to its number of members and financial ability; and

Whereas, the Medical Society of New Jersey increases its political impact in proportion to its participation in the American Medical Association; now therefore be it

RESOLVED, that the Medical Society of New Jersey adopt a unified membership policy and that membership in the American Medical Association be mandatory for all Medical Society of New Jersey members.

Adopted (142 in favor; 83 opposed). The recommendation of the Reference Committee had been for rejection.

#18

Introduced by: **Mercer County Medical Society**

Subject: **EXTEND AN INVITATION TO THE STATE BOARD OF MEDICAL EXAMINERS TO DELIVER A REPORT AT MSNJ'S ANNUAL MEETING**

Referred to: **Reference Committee "A"**

Whereas, the New Jersey State Board of Medical Examiners is the principal regulatory body of medical practice in the State of New Jersey; and

Whereas, there have been major areas of disagreement in the past between the State Board and the Medical Society of New Jersey (amphetamine legislation and the issue of physician harassment); and

Whereas, the need is appreciated by the Medical Society of New Jersey for closer understanding and cooperation; now therefore be it

RESOLVED, that the President of the New Jersey State Board of Medical Examiners or his designate be invited to deliver a report of the year's activities of the State Board of Medical Examiners before the physicians of the Medical Society of New Jersey at its Annual Meeting; such report shall cover areas of mutual dialogue and interest during the past year.

Adopted in accordance with the recommendation of the Reference Committee.

#19

Introduced by: **Herman M. Robinson, M.D., Delegate**
Essex County

Subject: **REJECT THE PROPOSED REVISION OF THE CODE OF MEDICAL ETHICS OF THE AMA**

Referred to: **Reference Committee "A"**

Whereas, the proposed revision to the AMA Principles of Medical Ethics is too broad and philosophical to enable the medical community to adhere uniformly to a standard of professional behavior; and

Whereas, society has a right to expect clear and understandable bounds of ethical behavior; and

Whereas, previous Judicial Council decisions have refined the meaning of the Principles of Medical Ethics; and

Whereas, the present Principles of Medical Ethics has been tested and modified and found acceptable to a majority of physicians; and

Whereas, the largest medical society in the United States, the California Medical Association, has rejected the revised Principles of Medical Ethics; now therefore be it

~~RESOLVED, that the House of Delegates of the Medical Society of New Jersey reject the proposed revision of the AMA Principles of Medical Ethics, except for deletion of gender.~~

Reference Committee recommendation was for rejection. The following Substitute Resolution #19 was offered by the House.

Substitute #19

Subject: **PROPOSED REVISION OF THE CODE OF MEDICAL ETHICS OF THE AMA**

RESOLVED, that the House of Delegates of the Medical Society of New Jersey commend the AMA Ad Hoc Committee on Principles of Medical Ethics for a job well done; and be it further

RESOLVED, that the Medical Society of New Jersey support the report of the Ad Hoc Committee with the contained proposed revisions of the "Principles of Medical Ethics," while at the same time requesting the Ad Hoc Committee to consider carefully all suggestions from the grass-root level in preparing its next submission to the AMA's House of Delegates.

Adopted

#21 (E)

Introduced by: **Union County Medical Society**

Subject: **REQUEST FOR REMOVAL OF AMA ENDORSEMENT OF PHYSICIANS' ASSISTANTS**

Referred to: **Reference Committee "A"**

Whereas, the recent article in the May 2, 1980, *AMA News* entitled "More Use of Physicians' Assistants May Not Cut Costs," stated: "Further use of Physicians' Assistants and nurse clinicians could raise overall cost of health care in the United States"; and

Whereas, this study was conducted by the Iowa Department of Health; and

Whereas, the article further stated, "By 1980, when an oversupply of physicians is predicted, there will be some forty thousand new health practitioners available"; now therefore be it

RESOLVED, that the New Jersey Delegation to the AMA lead a movement to remove endorsement of Physicians' Assistants by the AMA and by each state medical society.

Adopted. The recommendation of the Reference Committee had been for rejection.

REFERENCE COMMITTEE "B"

Christopher Babigian, M.D., Bergen
Chairman
William A. Dwyer, Jr., M.D., Passaic
Robert J. Lorello, M.D., Essex
William E. Ryan, M.D., Mercer
Isabelo S. Torio, M.D., Middlesex
David L. Sharp, M.D., Hunterdon
Alternate Member

Reports:
Treasurer
Committee on Finance and Budget (Supplemental)
Committee on Medical Student Loan Fund
Committee on Publication

Treasurer

Rudolph C. Gering, M.D., Treasurer, Pennington

(Reference Committee "B")

These interim financial statements have been prepared in accordance with the new accounting system recommended by our external auditors, Ernst and Whinney. Since these are interim statements the figures are unaudited. However, a complete audit will be conducted of the books of the Society as of May 31, 1980 and an audited report prepared as of that date. A complete audit was made as of May 31, 1979.

Filed in accordance with the recommendation of the Reference Committee.

Balance Sheet—January 31, 1980 (Unaudited)

Assets		
Cash		$ 122,030
Marketable securities—at cost (approximates market)		1,736,920
Accounts receivable—member assessments		471,052
Medical Student Loans (Net of allowance for doubtful loans of $51,865)		286,125
Notes receivable—Physicians		20,800
Property, Plant and Equipment		
Land	$ 150,000	
Building and improvements	1,800,681	
Furniture and fixtures	296,202	
Construction in progress	156,832	
	2,403,715	
Less allowances for depreciation	(95,517)	2,308,198
Prepaid expenses		42,021
Other assets		24,506
		$5,011,652
Liabilities and Fund Balance		
Accounts payable and accrued expenses		$ 152,277
Assessments collected for AMA		201,875
Assessments collected for NJFHCE		95,185
		449,337
Mortgage Payable		1,598,777
Deferred revenue from member assessments		1,375,000
Deferred professional liability assessments		756,048
Fund Balance		832,490
		$5,011,652

Statement of Revenue and Expenses
Eight Months Ended January 31, 1980—(Unaudited)

Revenue	
Membership dues	$ 846,450
Publication sales and advertising income	122,546
Amortization of professional liability assessments	123,050
Investment income	78,361
Rental income	13,508
Annual meeting	11,457
Other income	90,693
Total Revenue	1,286,065
Expenses	
Conferences and meetings	210,401
Member services	132,109
Publications	108,185
Grants to medical institutions	10,000
Total Program Expenses	460,695
General and administrative	582,082
Interest	93,630
Depreciation	40,908
Total Expenses	1,177,315
Excess of Revenue Over Expenses	108,750
Fund Balance at June 1, 1979	723,740
Fund Balance at January 31, 1980	$ 832,490

Finance and Budget

Richard E. Lang, M.D., Chairman, Passaic

(Reference Committee "B")

The Committee on Finance and Budget met on Wednesday, March 19, 1980 for the purpose of reviewing the proposed budget for the 1980-1981 year.

The committee makes the following recommendations to the Board of Trustees:

1. That the Budget for 1980-1981 in the amount of $2,222,000 with $1,750,000 to be raised through member assessments be adopted.

Approved

2. That the 1981 assessment be set at $230 per regular dues-paying member.

Approved

3. That the 1981 assessment be set at $20 per member for affiliate and associate members.

Approved

4. That the 1981 assessment be set at $5 per student for medical students.

Approved

5. That a special assessment of $20 be levied for the New Jersey Foundation for Health Care Evaluation.

Approved

Filed in accordance with the recommendation of the Reference Committee

Statement of Revenue and Expenses
for Proposed Budget
Fiscal Year Ending May 31, 1981

Revenue (other than member assessments)	
Advertising income	$ 93,000
Amortization of professional liability assessment	220,000
Investment income	84,500
Rental income	62,000
Annual Meeting	2,500
Other income	10,000
Total	472,000

Expenses	
Conferences and meetings	325,500
Member services	360,000
Publications	175,000
Grants to medical institutions	13,000
Total Program Expenses	873,500
General and administrative	1,117,500
Interest	159,000
Depreciation	72,000
Total Expenses	2,222,000
Amount of expenses over revenue to be raised through member assessments (including Journal subscription and Annual Meeting assessment)	$1,750,000

$1,750,000 ÷ 7,600 = $230.00

Proposed Budget
Fiscal Year Ending May 31, 1981

	Adopted Budget 1979-80	Estimated Y/E 5/31/80 (8 mos. Actual) (4 mos. Estim.)	Proposed Budget 1980-81
Compensation			
Salaries	$ 517,000	$ 499,612	$ 620,000
Pension Plan	63,000	63,010	80,000
	580,000	562,622	700,000
Professional Fees			
Audit	14,000	17,539	12,000
Legal	13,000	8,500	15,000
Actuarial	2,400	1,560	2,000
Special Consultants	24,000	10,438	30,000
	53,400	38,037	59,000
Councils and Committees			
Public Relations	125,000	139,000	139,000
Legislation	10,000	7,000	12,000
President and Presidential officers	33,000	31,000	35,000
AMA Delegates	37,000	35,000	34,000
MSNJ Auxiliary	11,000	11,000	14,000
Medical Education	28,000	29,197	29,000
Board of Trustees	35,000	42,000	45,000
Judicial Council	3,000	1,000	1,000
Reimbursement of Representatives to meetings	7,960	3,000	3,500
Other Councils and Committees	18,000	12,958	13,000
	307,960	311,155	325,500
Membership Service			
Membership Directory	40,000	(5,584)	60,000
Annual Meeting	—	75,000	80,000
PLI Expenses	—	203,051	220,000
	40,000	272,467	360,000
Donations			
CMDNJ-Foundation	10,000	10,000	10,000
Medical Student Loan Fund	3,000	3,000	3,000
	13,000	13,000	13,000
General Administrative and Operating Expenses			
Building Operations— (including depreciation)	322,000	309,430	359,000
Insurance	36,000	51,825	61,000
Payroll taxes	36,000	43,564	50,000
Other general office cost	48,000	105,954	119,500
	442,000	510,773	589,500
Journal	—	165,585	175,000
Reserves			
House	18,000	—	—
Contingency	25,640	—	—
Addition	20,000	—	—
	63,640	—	—
Total	$1,500,000	$1,873,639	$2,222,000

Medical Student Loan Fund

Palma E. Formica, M.D., Chairman, High Bridge

(Reference Committee "B")

In its twenty-three years of operation the Medical Student Loan Fund has granted loans totaling $608,700.

To date, the Fund has issued 484 loans to 299 New Jersey residents attending medical school. Two hundred and eighteen loans have been repaid in full. Thirty-six borrowers are presently making quarterly loan repayments. Thirty-six others are making quarterly interest payments until the notes become due. This year, twenty-four loans, totaling $28,500, have been paid in full.

Thirty-six requests for financial assistance by New Jersey medical students were received during the 1979-80 administrative year and twenty-seven loans of $1,500 each were granted for a total of $40,500. At the end of February 1980, six are in the final processing stage. If these meet all requirements, an additional six loans will be awarded making the total thirty-three. This represents an increase of six loans ($9,000) over those awarded during the previous administrative year.

It is estimated that the Fund will have $60,000 available for loans for the 1980-81 academic year. Of this $24,000 is committed to sixteen reapplicants. The remainder ($36,000) will be distributed to twenty-four new applicants.

In view of the escalating medical school tuition, high interest rates on loans, and the inflationary impact on the cost of living, more students will be faced with the need to seek loans. It seems more prudent to keep the yearly loan limit at its present level while striving to make loans available to additional students who qualify.

Your Committee has been greatly encouraged by the number of loans paid in full during the current year. The financial activities of the Medical Student Loan Fund are included in the report of the Treasurer.

Your Committee is deeply grateful for the dedication and interest of the student interviewers and warmly commends Miss Patricia Drakeford and Mr. Matthew Squreck for their administrative assistance.

PRESENT LOCATION OF RECIPIENTS OF LOANS

The 135 graduates with loans outstanding are located as follows:

Interns—4 in New Jersey and 16 out-of-state	20
Residents—11 in New Jersey, 54 out-of-state and 1 in Canada	66
Armed Services—1 Army of the United States and 1 United States Navy	2
Private Practice—	
1 Alabama / 7 California	
1 Connecticut / 3 Florida	
1 Hawaii / 1 Illinois	
1 Maryland / 2 Massachusetts	
16 New Jersey / 3 New York	
1 North Carolina / 5 Pennsylvania	
1 South Carolina / 3 Virginia	
1 Washington, D.C.	47
Students presently in medical school—1—5th Channel, 13 seniors and 13 juniors	27
Current loans outstanding	162
Medical Students paid in full (219 loans)	137
Total New Jersey Medical Students (as listed earlier)	299

DISTRIBUTION OF LOANS

Since 1957, 299 students from eighteen counties attending forty-three medical schools have received a total of $608,700. Loans granted for 1979-80 went to residents of nine counties in eleven medical schools and one CMDNJ-5th Channel Program. The complete list of loan distribution by county of residence, medical school, and the amounts of loans granted is on file at the Medical Society Offices and is available for review.

CONTRIBUTIONS

The Committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of contributors since the last report follows:

(1) General Fund:
MSNJ's Auxiliary Executive Board; County Auxiliaries: Atlantic, Bergen, Burlington, Camden, Cape May, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic, Salem, Union and Warren. Medical Societies: Bergen, Burlington and Cape May. Shahrokh Ahkami, M.D., Mrs. Cyrus Ahmadi, Dr. and Mrs. Samuel Baum, Mrs. Richard Bloomenstein, Mrs. J. Duff Brown, Dr. and Mrs. Robert A. Cornwell, Mrs. Margaret M. DeYoe, Mrs. William Dodd, Mrs. Richard Fadil, Mrs. Robert Fernand, Dr. and Mrs. Philip Fiscella, Mrs. Mary P. Gamon, Mrs. Armando Goracci, John and Carl Gould, Mrs. Douglas Hammett, Mrs. Kuchak Jalali, Dr. and Mrs. Alexander Karfopoulos, Dominic Kujda, M.D., Dr. and Mrs. John F. Kustrup, Dr. and Mrs. Arthur Lawrence, Mrs. Andrew McBride, Jr., The Drs. Morrow, Farah Pajoohi, Dr. and Mrs. Paul H. Pettit, Mrs. Edward Podgorski, Mrs. Paul E. Rauschenbach, Gloria T. Scarano, Mrs. Samuel Schlyen, Mr. and Mrs. Robert A. Smith, Miriam Smolev, Orell B. Taber, Dr. and Mrs. Carl Ware, Dr. and Mrs. Irving Weiss and Dr. and Mrs. Mohamad H. Zanjanian.

(2) In Memory Of:
Frank D. Bellucci, M.D., Dr. and Mrs. Sam Bernson's son, Mrs. Bluestein, Charles L. Brennan, Sr., M.D., Salvatore Cardullo, Agnes Wehrle Carroll, Edward T. Cicione, M.D., Joseph Crecca, M.D., Mrs. Francesco D'Imperio, William E. Dodd, M.D., Mr. Kenneth Drakeford, Mrs. Paul G. Ebner, Marcos Fath, M.D., Mrs. Russell D. Geary, Mrs. Elmer Geissler, Evangeline Gevas, Edward C. Greene, M.D., W. Herbert Hanna, Mrs. Lena Jent, Frederick J. Kiefner, Mrs. Rose Kinczel, Maxwell Klausner, M.D., Mrs. Evelyn Klimesz, Mrs. Ralph Lanciano, William Mountford, M.D., Albert Oppenheimer, M.D., Franklin F. Reichert, Susan Rosen's grandfather, George C. Schwarzkopf, M.D., William I. Spruill, Howard Stainton, Irene Staurellis, Thomas J. Summey, M.D., Than Tsoukas, Linton Turner, M.D., Mrs. J. Alonzo Williams and Fanny Zuckerman.

(3) In Honor Of:
Passaic County Medical Society Auxiliary Executive Board. Dr. and Mrs. Richard Fadil, Edward Robert Fernand, Mrs. Douglas Hammett, Mrs. J. James Pegues and Mr. and Mrs. John Quigley.

RECOMMENDATIONS

(a) That the House of Delegates concur in the recommendation of the Finance and Budget Committee—approving a budget appropriation of $3,000 in lieu of a special per capita assessment for 1980-81 in support of the Medical Student Loan Fund.

Approved in accordance with the recommendation of the Reference Committee.

(b) That the MSNJ membership be urged to continue its active support by sending contributions to the Fund.

Approved in accordance with the recommendation of the Reference Committee.

(c) That the Medical Society of New Jersey Auxiliary be requested to make the Fund its number one project next year.

Approved in accordance with the recommendation of the Reference Committee.

Filed in accordance with the recommendation of the Reference Committee.

Publication

John F. Marshall, M.D., Chairman, Trenton

(Reference Committee "B")

The Journal continues to make major changes in the interest of becoming more informative, educational, attractive, and readable—most recently by inclusion of:

1. A monthly Professional Liability Commentary prepared by the staff of MSNJ's Department of Professional Liability Control.
2. "Readouts" within scientific articles to highlight important statements.
3. A section entitled "Your Congressman Speaks." Thus far, in 1980, presentations have been made by Senator Williams, Congresswoman Fenwick, and Congressmen Courter and Patten.
4. A series of "State-of-the-Art" articles are being prepared by members of the Manuscript Review Board and others.
5. An item entitled "The Electrocardiogram," which is written for the noncardiologist.

Another feature under consideration is an OP-ED page. It is developing slowly because of difficulty in finding members willing to submit written opinions on controversial subjects.

An effort is made to provide interesting covers—many of which tie in with editorial or scientific material contained in that issue. Others of purely esthetic value are from photographs provided by our members.

The Manuscript Review Board, which has improved the quality of the scientific articles, has been enlarged to include members in the fields of otolaryngology, neuroscience, nephrology, endocrinology, gastroenterology, and dermatology.

In addition to the publication of the monthly *Journal*, the *Journal* staff is charged with the preparation of the Annual Reports printed booklet which is distributed to the members of the House of Delegates about a month in advance of the Annual Meeting, and with preparation of the Official Transactions of the House of Delegates, published as a second issue of *The Journal* in mid-July.

The Journal's operational budget is now an integral part of the Society's annual budget. This inclusion will enable the *Journal* staff, the Publication Committee, and others more accurately to forecast and plan for budgetary needs. Progress continues to be made toward a more balanced source of advertising revenues as well as increased revenues. The comparison of insertions during the calendar years 1978 and 1979 clearly shows most recent advances.

	1978	*1979*	*% Increase*
Pharmaceutical Ads	$52,728	$61,643	17
Non-Pharmaceutical Ads	$25,186	$35,136	39
Total Ads	$77,914	$96,779	24

(Advertising rates for full and one-half pages were increased as of January 1980 by eight percent from 1978-1979).

The use of new printing techniques (particularly WEB offset presses) has enabled *The Journal* to hold the line on production costs. Paper and postage costs are rising much faster than inflationary trends and cannot be controlled.

Filed in accordance with the recommendation of the Reference Committee.

REFERENCE COMMITTEE "C"

Adolph R. Wichman, M.D., Morris
Chairman
Richard H. Dupree, M.D., Gloucester
Roland E. Johnson, M.D., Sussex
Robert G. Salasin, M.D., Cape May
B. Ralph Wayman, Jr., M.D., Mercer
Alternate Member

Reports:
Board of Trustees' Item
Medical Inter-Insurance Exchange of New Jersey
Department of Professional Liability Control
Committee on Medical Defense and Insurance
Committee on Retirement Plan for Physicians

Board of Trustees' Items

BLUE SHIELD BOARD OF TRUSTEES
(Reference Committee "C")

In December, the Board of Trustees reviewed applicable conflict of interest and antitrust laws, as well as developing trends in these areas as they may be applicable to the relationship of the Medical Society of New Jersey to outside organizations.

In order to avoid even the slightest question of impropriety, the Board agreed that no officers or staff members of the Medical Society of New Jersey should sit on the Board of Blue Shield as a representative of the Medical Society of New Jersey.

Filed in accordance with the recommendation of the Reference Committee.

BLUE SHIELD REGULATIONS
(Reference Committee "C")

Resolution #12 from the 1979 Annual Meeting (first resolved) called for the Board of Trustees to effect a change in Blue Shield regulations that would allow participating physicians to receive fees from major medical carriers.

A report from the Executive Director indicated that the action requested only could be effected by amending the participating physician contract.

Blue Shield has agreed that it will allow recovery where the patient is over-income, but not when "service benefits" are involved.

The second resolved called for the Society's Board of Trustees to pursue the matter with the State Department of Insurance. The Department has indicated that the problem is a contractual one that is not subject to regulatory change. The participating physicians would have to secure an amendment to the participating physician contract.

The Executive Committee has been instructed to pursue the matter with Blue Shield in order to accomplish the intent of the resolution.

Filed in accordance with the recommendation of the Reference Committee.

PHYSICIAN PARTICIPATION ON BOARDS OF BLUE CROSS-BLUE SHIELD
(Reference Committee "C")

The Board of Trustees developed the following position predicated on an inquiry from the Federal Trade Commission pertaining to the composition of the boards of Blue Cross-Blue Shield:

There should be no limitation on the number of physicians elected or appointed to the Board of any Blue Cross or Blue Shield Plan; and that individuals should be elected to these Boards, based upon their achieving a majority vote of the policyholders/shareholders, as in any other corporate structure or insurance entity.

Filed in accordance with the recommendation of the Reference Committee.

New Jersey State Medical Underwriters, Inc.
Medical Inter-Insurance Exchange of New Jersey

Vincent A. Maressa, Secretary-Treasurer

(Reference Committee "C")

PRODUCTION

Written premium at the close of 1979 was $28,164,469. The total number of insureds was 5,788. Renewal binders were sent out the week of Janury 21, 1980. The renewal process has been slowed by the delayed action of the Insurance

Department on the rate filing and a breakdown in computer equipment. We expect to complete the renewal phase by early March 1980.

BUDGET

The Underwriter performed within budget parameters this past year. Anticipated increases in office space requirements, claims staff, and computer personnel will, along with inflation, require budgetary expansion for 1980/1981. The new budget will be presented to the Board of Governors for their action on March 26, 1980, and is predicated on a 7 percent expense objective.

CERTIFICATE REDEMPTION

Through January 31, 1980, a total of 379 certificates have been redeemed in the aggregate amount of $1,181,700 in accordance with the Offering Circular protocol.

CLAIMS STATUS

From February 1977 to January 31, 1980, a total of 1,376 claims have been asserted against 1,737 named insureds. 843 claims against 1,078 insureds are open. 533 claims against 659 insureds have been closed.

Indemnity payments on closed files have been $8,276,916. Expenses on closed files stand at $171,545 (a remarkably low ratio).

Indemnity payments on open files are $34,169. Expenses on these files have been $234,610.

Outstanding indemnity reserves are $19,897,909. Outstanding expense reserves are $2,880,510.

Some 311 claims have been closed without payment.

Thus far, ten cases defended by the Underwriter have gone before Supreme Court Screening Panels (R. 4:21). Eight were ruled "no cause," one was ruled "cause," and one was found "no cause" by a split decision.

Filed in accordance with the recommendation of the Reference Committee.

Department of Professional Liability Control

James E. George, M.D., J.D., Director, Woodbury

(Reference Committee "C")

The Department of Professional Liability Control recently hired an assistant director to aid in the expeditious development of preventive programs and projects for Society members.

A capsule of the various affairs conducted by the Department follows:

PHYSICIAN LEGAL BULLETIN

Four times this year the Department published and mailed to all Society members a bulletin relative to medicolegal topics. The Department has complied with numerous requests from individuals and organizations for copies of the *Physician Legal Bulletin.* It is our opinion that the *Physician Legal Bulletin* has been well received by the Medical Society members and other interested parties.

PROFESSIONAL LIABILITY COMMENTARY

Beginning with the November 1979 issue of *The Journal,* MSNJ, the Department publishes a monthly commentary designed to inform members of the Society of mutual concerns and to provide general information regarding professional liability.

SEMINARS

The Department has conducted medicolegal seminars for the New Jersey Urological Society, the New Jersey Chapter of the American Academy of Pediatrics, the New Jersey Society of Plastic and Reconstructive Surgeons, the Medical Students Association of the College of Medicine and Dentistry of New Jersey, the Gloucester County Medical Society, and the Pediatric and Obstetrical/Gynecological staff of Valley Hospital. Plans presently are being formulated for conducting medicolegal seminars for two specialty societies' annual meetings. Participating physicians have expressed positive comments regarding the information and worthiness of the seminars. Category 1 CME credit has been granted for these seminars.

LEGAL RESEARCH ASSISTANT

The Department advertised, interviewed, tested, and selected six part-time legal research assistants for use in current and future projects as they materialize and develop.

COMMUNICATION

The Department communicated in writing and orally with the Chairman of the New Jersey Medical Malpractice Reinsurance Association and with the Vice-President of the Health Care Insurance Exchange in order to promote a climate of cooperation in our goal to better serve all members of the Medical Society.

ANNUAL MEETING

The Department, in cooperation with the Administrative Director of the Courts, has planned a program regarding Rule 4:21 for the Annual Meeting in May.

VIDEO TAPING PROJECT

In January, 1980, the Department began the first phase of an experiment in the use of video taping as a medicolegal learning instrument. Each tape reviews two medical specialty liability cases and is designed to promote discussion from the viewers at the conclusion of the presentation. A pre-test/post-test is being developed which might meet the granting of CME credit for participating physicians. If the experiment proves successful the Department will develop a portfolio of video tapes. Distribution of this material is currently under study.

Filed in accordance with the recommendation of the Reference Committee.

Medical Defense and Insurance

Michael J. Doyle, M.D., Chairman, Neptune

(Reference Committee "C")

In 1979, the major changes affecting our plans were as follows:

1. The Major Expense plan was improved effective November 15, 1979, without additional cost as follows:

Basic Coverage: Nursing benefit covered expense increased to $50 per shift (up to $150 per day) for both non-Medicare and Medicare-eligible participants. (Eighty percent of full covered nursing charge continues in the Million Dollar Umbrella.)

Umbrella Coverage: Maximum benefit increased to $1,000,000—a fourfold increase.

Optional Professional Fee Coverage (available to non-Medicare eligible participants): Physicians' fees in hospital allowance increased to $40 first visit, and $20 for subsequent daily visits—payable in addition to Blue Shield allowance. The surgical and anesthesiological schedule remains the same and is also payable in addition to Blue Shield allowance.

2. Last year the Committee studied and approved the offering of an additional life insurance program to the members providing insurance protection in a range beyond that of our present policies.

The new program in the Occidental Life Insurance Company of California will provide $100,000 to $1,000,000 of coverage on a deeply discounted, yearly renewable, term basis. The plan's cost is approximately five percent lower than the comparable individual policies offered by the company. This program will be introduced in the middle of 1980 as an additional life insurance service for the members.

ACCIDENT AND HEALTH INSURANCE

The Society's accident and health insurance programs are administered by the E. & W. Blanksteen Agency, Inc., who just have completed their 49th year of service to our members. This comprehensive income program now affords a monthly benefit of up to $4600 during total disability due to injury or sickness. The program consists of two parts: The Basic Plan and the Long-Term Plan. The Plans differ primarily in the length of time benefits are payable. For an accident disability, the Basic Plan pays up to five years, the Long-Term Plan up to lifetime. For a sickness disability, the Basic Plan pays up to two years; and the Long-Term Plan up to age 65 and beyond. Both the basic Plan and the Long-Term Plan are underwritten by the Nationwide Mutual Insurance Company. Members may carry up to $4600, of which up to $4000 may be in the Basic Plan and up to $4000 a month in the Long-Term Plan. Up to three policies are issuable to any member for maximum flexibility. The Company will rearrange policies and existing coverage to accommodate changing needs within the three-policy limit.

BASIC PLAN

The Basic Disability Plan provides as much as $4000 monthly benefit. Benefits are payable from the first day of accident total disability for as long as five years and the eighth day of sickness total disability for as long as two years. Waiting periods of 30 or 60 days are available to provide reduced premiums for those whose circumstances make desirable a plan where benefits could begin on a later date than 1st day accident and 8th day sickness. The plan also pays, at half the monthly rate, accident partial disability benefits for as long as six months. Also included in the plan are accidental death and dismemberment benefits. There are 3659 basic policies covering our members, with some members having two basic policies. It is the practice of the administrator to combine two basic policies into one whenever members revise or increase their insurance programs so as to simplify their recordkeeping.

LONG-TERM PROFESSIONAL INCOME PROTECTION PLAN

Members may carry up to $4000 under this plan. Benefits are payable for lifetime for accident total disability and to age 65 and beyond for sickness total disability. One of the chief purposes of this plan is to provide both accident and sickness disability benefits to the age where other financial arrangements begin to fall into place; such as annuities, life insurance settlement options, and Social Security. The plan also affords six months of accident partial disability benefits at half the monthly benefit rate. Benefits may begin from the 1st day accident, 8th day sickness, or 1st day hospitalization, —or from the 15th, 31st, 61st, 91st or 181st day of disability, with appropriate reductions in premium. Currently 2144 members participate in this program which began in 1965.

It is possible for a member to have the various disability plans in almost any combination of monthly benefit and plan to fit personal requirements. The ideal goal for most doctors is to insure about two-thirds of monthly gross income. More monthly benefit than this is unnecessary inasmuch as all benefits are tax free for Federal income-tax purposes. Members who apply for the Basic plan within their new-member periods are issued coverage, within certain limits, without regard to medical history.

All of our accident and health policies have the guaranteed Conversion Provision Rider. Briefly, this rider provides that if Nationwide were unilaterally to terminate any of its accident and health insurance programs for members of the Society, the Company is committed to issue a guaranteed renewable policy for the same benefits as are provided for in the doctor's original policy.

MAJOR EXPENSE PLAN

The Society's Major Expense plan was transferred to the Nationwide Life Insurance Company and a new, improved program put into effect, making professional fee coverage available for the first time under this program as an option to policyholders who are not eligible for Medicare benefits. This program is especially designed to work in conjunction with any Blue Cross and/or Blue Shield contract you may carry. The combination of the new $200 deductible Million Dollar Major Expense Plan and some basic hospital coverage can provide excellent protection for you. There are 1870 of our members participating in this plan.

The coverage consists of two parts:

1. **Basic Coverage**—The $15,000 basic coverage is subject to a $200 deductible and is paid *regardless of any other insurance or service plan you may have.* Basic coverage provides 100 percent of $40 per day toward hospital room and board in addition to any Blue Cross or Basic hospital coverage, $50 a shift for nursing (RN or LPN in hospital; RN out of hospital) and the scheduled amounts of the optional professional fee coverage.

In addition, it provides 80 percent of various services and supplies when out of the hospital. It may include professional fee coverage on an optional basis as described in the folder. All professional fee payments are, as is all basic coverage, paid in addition to other payments—in particular, Blue Shield.

2. **Million Dollar Umbrella Coverage**—This coverage is designed to take over where Blue Cross leaves off and becomes operative when $15,000 of umbrella covered expense has been incurred. Umbrella covered expense consists of 100 percent of full semi-private hospital care including miscellaneous hospital expense, full nursing charges in-hospital and 80 percent of certain services and supplies out of the hospital. Payments are made under the Million Dollar Umbrella coverage to the extent that they have not been paid by other policies, including this one. **But**—the Basic $40 daily hospital benefit and the full semi-private benefit under the Umbrella can be payable simultaneously. This makes certain that payment will be made in the event the insured is confined to a private room in the hospital.

Thus, participants are assured of virtually complete hospital and nurse coverage even after Blue Cross benefits have ended. Umbrella-covered expenses do not include expenses eligible for payment by Medicare.

Unmarried, dependent children are covered to age 25. All members who are under age 70 and their spouses under age 70 are eligible to apply. At eligibility for Medicare, coverage for such person automatically becomes modified Basic Coverage with a $15,000 maximum for each covered person, with a deductible of $750 or the amount of covered expenses payable by Medicare, whichever is greater. Medicare Covered Expense includes hospital miscellaneous services. The optional Professional Fee Coverage does not continue for those eligible for Medicare. Full coverage continues for covered persons not eligible for Medicare. The program is administered by E. & W. Blanksteen.

HOSPITAL-MONEY PLAN

Our Hospital-Money policy, administered by E. & W. Blanksteen Agency, Inc., provides $20, $30, $40, $50 or $60 a day for each day of hospital confinement up to a maximum of 365 days for any one confinement. It can cover member, spouse and dependent children. New members are able to obtain the $20-a-day program nonselectively as part of their new-member privilege. Benefits under this plan are paid regardless of other insurance and are used to supplement the benefits provided by Blue Cross, Major Expense and Major Medical plans. It is particularly useful to provide money for private-room coverage where adequate provision is not made by underlying plans. Two hundred thirty-five members participate in this program.

OVERHEAD EXPENSE PROGRAM

Many of our members find that their overhead expenses have become quite high, with employees' salaries, rentals and other fixed expenses pertaining to their practice. Our Professional Overhead Expense Program is underwritten by the National Casualty Company and administered by the E. & W. Blanksteen Agency, Inc. It provides up to $5,000 monthly benefit beginning with the 31st day of total disability and lasting as long as two full years. Currently 503 members are covered under this plan. In accordance with I.R.S. regulations, the premiums under this program are considered business expense *and are tax deductible.*

LIFE INSURANCE—NATIONWIDE LIFE INSURANCE COMPANY and BANKERS LIFE COMPANY OF DES MOINES, IOWA

The maximum coverage under our Life Plan is $250,000 with the $100,000 maximum coverage Bankers Life Plan available in addition to the $150,000 program of the Nationwide Life Insurance Company that has been in effect for many years. Our original Nationwide Life Insurance program includes not only the member but also his spouse and dependent children (between the ages of 15 and 21; up to age 26 if a college student), as well as employees. An important feature of this expansion is that each person will have his own Five-Year Renewable and Convertible Term policy and it is not necessary for the member to take out insurance for himself in order to provide coverage for a member of his family or an employee. This added feature enables the life insurance program to serve many more needs of our members, especially those who wish to provide benefit programs for their employees. The administrators are E. & W. Blanksteen Agency, Inc.

The Nationwide life program provides each insured person with a Five-Year Renewable and Convertible Term policy with a guaranteed conversion on a non-medical basis to permanent life insurance at any time. The program now provides up to $150,000 of coverage for members and up to $50,000 of coverage for spouse, dependent children and employees. All coverage is issued in the form of convenient units of $10,000 with waiver of premium and double indemnity for accidental death included without premium charge. Since inception of the program, there have been 409 death claims, resulting in a total payout of $4,478,000.

As a result of the large volume of insurance and strong participation of our members in this program we are able to have non-cancellable term life insurance at a very low cost. At the present time, over 1,800 of our members participate in the program with approximately $31,000,000 of insurance currently in force. This plan is also available to spouses, children and employees and 130 of them participate in this program.

The additional $100,000 coverage through the Bankers Life Company is available to members whether or not they carry insurance under the original program. This will make possible larger amounts of insurance without the necessity of another physical examination and give our members even greater flexibility in establishing their insurance program. The net cost and structure of the Bankers Life Program is quite similar to that of the Nationwide Life Insurance Company described above.

Of our members, 226 so far have applied for and were issued $9,227,500 of insurance protection under this new plan.

SIX-POINT, HIGH-LIMIT ACCIDENT INSURANCE PLAN

Our Six-Point, High-Limit Accident Insurance Plan with

the Nationwide Life Insurance Company, administered by E. & W. Blanksteen Agency, Inc., provides up to $200,000 for accidental death benefit with dismemberment benefit, loss of sight, exposure, disappearance and even a total disability feature at less than the usual cost of the accidental death benefit alone.

Coverage is issued under this program to members under the age of 70 in the active practice of medicine, without regard to medical history. We have a special Six-Point, High-Limit Accident Insurance Program enrollment at the beginning of each year. Special spouse coverage is available under this policy at very low cost. There are 594 of our members participating in this program.

PROFESSIONAL CORPORATION

The Basic-Extended, Long-Term Professional Income Protection Plan, Major Expense Plan, Hospital-Money Plan, Six-Point High-Limit Accident Insurance Plan, Overhead Expense Plan and Life Insurance Plan are adaptable for use in professional corporations and the necessary assignment forms are available upon request from the administrator.

RECOMMENDATION

That the E. & W. Blanksteen Agency, Inc., be continued as the the Official Broker for MSNJ's Accident and Health Insurance, Major Expense Insurance, Hospital-Money Plan, Life Insurance, Six-Point High-Limit Accident Insurance, and Professional Overhead Expense Plan.

Approved in accordance with the recommendation of the Reference Committee.

PROFESSIONAL LIABILITY

Peer Review—An effort is made to have the reviews conducted by the Exchange (Medical Inter-Insurance Exchange of New Jersey) take place within six months of the date of notification while the recollections of the witnesses and all the data are fresh. The Exchange is considering tailoring peer review to the presentation of two or three cases before a panel of four or five specialists with the defendants present.

The Committee recommended and the Board of Trustees approved that the Board of Governors of the Medical Inter-Insurance Exchange of New Jersey consider a surcharge type of penalty at the next policy renewal for physicians who do not cooperate with the peer review mechanism of the Exchange.

SUPREME COURT RULE 4:21

The Committe is pleased with the early reports indicating the success of the mandatory subpanel system. An extensive program on this topic will be available at the Annual Meeting. For additional information see the annual report submitted by the New Jersey State Medical Underwriters, Inc.

HEALTH INSURANCE

Close to 6,000 member doctors and employees were covered by the Statewide Blue Cross/Blue Shield Program at the end of 1979. Good claims experience during the plan year, which ended November 30, 1978, gave participating doctors a dividend of 11.81 percent of the total paid premium. Claims experience figures for the plan year ending in 1979 are not yet available. Premium rates for this coverage have been the same since July of 1978, at which time they were *decreased* for participating member doctors and employees under age 65.

The Statewide Blue Cross/Blue Shield Program, administered by Donald F. Smith and Associates, provides members with basic health insurance protection that is both comprehensive and competitively priced. In addition to providing 120-day Blue Cross coverage (for hospital services) and a choice of the 500 Series, 750 Series or Prevailing Fee (UCR) Blue Shield schedules (for doctors' services), the Program also provides these additional benefits:

- 120-day semi-private care *per admission,* rather than per benefit year;
- *120-day coverage* for mental conditions, tuberculosis, polio and contagious diseases, rather than the standard 20 days;
- Payment of *full semi-private rate* in non-member hospitals outside of New Jersey, rather than the standard $30 per day payment;
- Coverage for unmarried children until the end of the year in which they reach *age 23,* rather than age 19.

The Program has no pre-existing condition exclusions and coverage is available to members regardless of their previous medical history. Coverage is also available for a member doctor's full-time employees if he or she wishes to provide it as a fringe benefit program.

Like the Statewide Blue Cross/Blue Shield Program, the Major Medical Program has continued to gain new participants. More than 2,500 doctors and employees from 18 counties are now covered by this program of supplemental health insurance.

On July 1, 1979, an 18 percent premium rate increase went into effect. The increase was due primarily to inflation: as the cost of health care rises, so must the cost of the insurance that covers health care. Despite the rate change, however, the cost of this coverage still compares favorably with the cost of other major medical plans having a similar level of benefits.

Benefits are payable when expenses for covered illnesses and accidents exceed the benefits available under the statewide Blue Cross/Blue Shield Program plus a calendar year cash deductible of $100.

Highlighted here are other key aspects of the Major Medical Program:

- Benefits are payable on expenses incurred in or out of the hospital.
- There are unlimited lifetime benefits. (The maximum benefit per person per calendar year is $50,000 except for out-of-hospital treatment of mental conditions, which is limited to $1,000 per person per calendar year.)
- Physicians' and surgeons' charges are covered expenses.
- The full semi-private hospital room and board rate is a covered expense. If a private room is medically necessary, there is an additional allowance.
- Unmarried children are covered until the end of the year in which they reach age 23.

Designed and administered by Donald F. Smith & Associates, the Major Medical Program is available to any member who has Blue Cross/Blue Shield coverage on a group basis. Coverage may also be provided for full-time employees as a fringe benefit.

At the end of 1979, a new, simplified claim filing system was put into operation. Only *one* claim form now has to be filled out and submitted to the insurer in order to receive

benefits, even if benefits are being sought under both the Blue Cross/Blue Shield and Major Medical Programs. Prior to this, two claim forms were needed. The first form went to Blue Cross/Blue Shield and the insured waited for payment under this coverage. When payment was received, a second form was submitted to Major Medical for payment on excess charges or declined services.

The new system allows one claim form to be forwarded from Blue Cross/Blue Shield to Major Medical and vice versa so that the benefits available under each coverage can be paid. The improvement has resulted in significantly less paper work and faster claim payments for both doctors and employees.

Also during 1979, the programs were affected by four pieces of legislation:

(1) In response to the New Jersey Law on Dependent Coverage, program contracts were amended to provide continued coverage for the dependents of deceased employees for up to 180 days. The contract already provided continued coverage for the dependents of deceased member doctors.

(2) The New Jersey Law on Alcoholism requires that alcoholism now be treated as any other covered illness or condition. The 120-day benefit also now covers treatment in approved detoxification and/or residential facilities.

(3) Pregnancy now also is treated in the same manner as any other covered illness or condition, a change made in response to the Pregnancy Discrimination Amendment to the 1964 Civil Rights Act.

(4) Coverage has been broadened to provide health care benefits for participating member doctors and employees who are age 65 and over. The expanded coverage brings the Programs into compliance with the Federal Age Discrimination in Employment Act guidelines.

RECOMMENDATION

That Donald F. Smith and Associates be continued as MSNJ's Offical Broker for its Blue Cross/Blue Shield Group Major Medical Program.

Approved in accordance with the recommendation of the Reference Committee.

Filed in accordance with the recommendaton of the Reference Committee.

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "C")

Both of the following plans administered by E. & W. Blanksteen Agency, Inc. and PRO Services, Inc. have been reviewed by the Committee and have been approved for sponsorship again this year.

HR-10 (KEOGH) VARIABLE ANNUITY RETIREMENT INVESTMENT PLAN

Our Keogh Plan provides tax-deductible contributions up to the lesser of $7500 or 15 percent of earned income. In addition, voluntary contributions of up to the lesser of $2500 or ten percent of earned income may be made, to take advantage of the tax-free compounding and favorable final funding guarantees. This plan, established in 1970, is administered by E. & W. Blanksteen Agency, Inc. and underwritten by The Prudential Insurance Company of America.

Last year, the Prudential revised the Fixed Dollar Account for contributions made after March 1, 1980. The new Fixed Dollar Account would have a stated rate of interest and would not be subject to interest adjustments when interest rates gyrate as they have in the past. The old Fixed Dollar Account, also known as the "Current Interest Account" had its interest rate raised to ten and a half percent on December 1, 1979, which necessitated an interest adjustment. While the interest adjustment does not affect the annuity value of the account, when interest rates rise it does affect, adversely, the immediate cash surrender value. Holders of the Current Interest Account were given the right, until February 29, to convert to the new Fixed Dollar Account retroactive to November 30—thereby obtaining a refund of the interest adjustment. The Prudential sent much explanatory material to the participants to enable them to decide upon their most advantageous choice.

The program includes unique advantages, in addition to the well-known tax-saving and tax-shelter features of the Keogh Law:

1. A lifetime monthly variable payout, based on a common-stock portfolio. (The Variable Annuity)
2. A lifetime monthly fixed-dollar annuity.
3. Contributions even beyond age 70-1/2, as long as you are self-employed.
4. A death benefit guarantee, so that if the participant dies during the accumulation period, his beneficiary will never receive less than the amount the participant has paid in.
5. Contributions can be made as often or seldom as you wish with no minimum requirements.

The plan has a splendid final funding mechanism consisting of a Group Variable or a Group Fixed-Dollar Annuity, combined with tax-free government bond distributions. Many members who accumulate their funds elsewhere find it beneficial to transfer to this program at age 70-1/2 and take advantage of the final funding arrangement.

Throughout the state, we have 462 plans in effect, covering 549 people (since a partnership has one plan for all its partners, a retirement plan covering a partnership may have more than one physician-participant) with total deposits of $6,868,323 since the plan's inception.

The Society has recognized that some of its members may see fit to practice in the form of a corporation. Therefore, the Committee recommended, and the Society approved in 1970, the establishment of The Medical Society of New Jersey Retirement Plan Trust-B, which adopted a Corporate Master Retirement Plan, using the same funding agents as the Keogh program described above. This program, in the form of a Master Profit-Sharing Plan, permits corporations, one of

whose employees is a member of the Society, to place up to 15 percent of payroll in a tax-sheltered program with the same flexibility and options as our Keogh program, using the Prudential Insurance Company's group Fixed-Dollar Annuity and group Variable Annuity.

This plan is administered by E. & W. Blanksteen Agency, Inc., who will be pleased to furnish members with full information concerning the plan, which should provide a substantial savings, since it is not necessary to have a plan and trust specially drawn for you. Many large corporations and other organizations use these same funding agents for their tax-deferred retirement plan, including that of our administrator.

PRO SERVICES, INC.

Benefits—One of the outstanding benefits to members is the availability of group retirement plans offered by our designated agent, PRO SERVICES, INC., and made available through the Medical Society of New Jersey. The plans offered are all IRS-approved master prototypes and include all of the following:

IRA—These include both the regular IRA with contributions of up to $1,750 per year and the new "Simplified Employee Pension Plan" which permits contributions of up to $7,500 annually.

Keogh—Two plans are available—Defined Contribution and Defined Benefit.

Corporate Pension and Profit Sharing—Master Prototypes are available to fit any individual need. These include money purchase, as well as various defined benefit arrangements.

Investment Performance—While members are free to select from a wide range of marketable investment alternatives, many members have chosen to use either PRO Fund, Inc., a common-stock mutual fund, or PRO Income Fund, Inc., a high-quality income mutual fund.

According to "Lipper Analytical Service, Inc.," a widely recognized independent mutual fund reporting service, PRO Fund, Inc. provided investors with an increase in value per share of 24.4 percent for the calendar year 1979, while PRO Income Fund, Inc., continued to maintain its high yield and performance among the high-quality income funds.

Medical Technology Fund, Inc., became effective for investment under the retirement plan in late fall (October) and finished the last quarter up 11.03. The fund is the only one of its kind and is engaged in seeking capital growth through the revolution occurring in the world's health care industry. Concentration of investment is in companies engaged in the design, manufacture or sale of products or services which are derived from technology for use in medicine or health care.

Guaranteed Issue Life Insurance—The Society always permitted life insurance as part of any of the Keogh or Corporate plans offered for those individuals who wish to use this feature.

In light of recent inflation and the important tax benefits now available from including life insurance in retirement plans, the amount of coverage available without proof of health has been liberalized substantially and is available up to $75,000.

DESCRIPTION OF THE PLAN OPTIONS AND FEES

The PRO Retirement Plans offer wide flexibility in selection of investment programs available under the plans.

Plan A

1. **Investment Options Available**
   a. PRO Fund, Inc. (i)
   b. PRO Income Fund, Inc. (ii)
   c. Medical Technology Fund, Inc.
   d. Annuity Savings Contracts
   e. Life Insurance
   f. U.S. Retirement Bonds
2. **Fee Schedule for Plan A**
   a. Annual maintenance and processing fee per participant—$36
   b. Partial or lump sum cash distribution—$1
   c. Return of excess contribution—$1
      (i) Invests primarily in common stocks
      (ii) Seeks highest investment income consistent with preservation of principal.

Plan B

1. **Investment Options Available**
   a. Individually selected common stocks, preferreds or corporate bonds.
   b. Shares of any investment company registered pursuant to the Investment Company Act of 1940 (mutual funds).
   c. Money market funds.
   d. Obligations (bonds) guaranteed by the United States.
   e. Certificates of Deposit. (Only in U.S. banks or savings and loan associations).
   f. Savings Accounts. (Only in U.S. banks or savings and loan associations).
   g. Life Insurance and/or Annuity Savings Contracts.
2. **Fee Schedule for Plan B**
   a. Asset fee (Includes purchases under a standing investment designation-Each Asset (excluding cash)—$2 monthly
   b. New Account or Full Termination (one-time charge)—$35
   c. Special Fees:
      i. Transactions not covered by a standing investment designation (asset contribution, purchase, sale, partial liquidation, participant loan)—$15
      ii. Broker directed transaction fees (regardless of number of transactions)—$10 monthly
      iii. Termination of Account—$25

Under both Plan A and Plan B, each participant may elect one or more of the options and change his investment selection as his needs or the investment climate change. Many participants select a combination of options.

A PRO structured and administrated retirement income plan maximizes benefits and cuts taxes now and in the future. It also relieves the employer of paperwork, legally required filings and management liabilities.

ADDITIONAL INFORMATION

The numerous advantages as well as a description of plan options and fees, are listed below.

ADVANTAGES

No Advisory Responsibility—The PRO Plans offer a broad range of investment possibilities—stocks, bonds, mutual funds, savings accounts, insurance, annuities and other liquid investments. The broad range of investment options best serves individual needs and frees the employer of advisory responsibilities.

No Investment Liability—Each participant selects investments to meet individual needs. The employer thus avoids fiduciary responsibility as well as liability as an investment advisor.

No Record-Keeping Accountability—There is no need to assume liability as trustee of your plan. PRO plans feature corporate bank trustee facilities to maintain account records and furnish individual reports to each plan participant.

Continuing Advice and Guidance—Participants and employees receive PRO Services' professional advice on coordinating retirement programs with lifetime financial objectives keeping programs current and deriving fullest possible benefit from every dollar put aside. Service is rendered from inception to fulfillment of each program.

Regular Services for Plan Participant—All Plan Employers are eligible for and may request any of the following services:

a. Annual "Checkup" Service
b. Assist Terminating Employees
c. Enroll New Employees
d. Contribution Reminder Notices

Full Compliance Service—On an optional basis, PRO Administrators, Inc., will act as your legal Plan Administrator. If this optional service is elected, PRO will assume the fiduciary responsibility for administrating your plan, and will be legally responsible for preparing and filing all required government reports during each year as they become due.

Flexible Retirement Payout—All legal retirement options are available under the plans. For example, a participant may elect a lump sum or partial distribution, select a monthly check, or purchase an annuity with monthly income for life.

Guaranteed Life Insurance Coverage—Life insurance is available in the PRO Plan without evidence of good health.

More information regarding these outstanding retirement plans is available by writing or calling the Society's officially designated service agent.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

#16

Introduced by: **Camden County Medical Society**

Subject: **NEW JERSEY BLUE SHIELD COMPENSATION FOR REQUIRED FIRST PHYSICIAN'S SURGICAL ASSISTANT**

Referred to: **Reference Committee "C"**

Whereas, under New Jersey Law (N.J.A.C. 13:25-7.1), first surgical assistants are required; and

Whereas, compensation for physician's surgical assistants was approved by Medical-Surgical Plan of New Jersey at the rate of 20 percent of the primary physician's fee for assistants in a surgical case; and

Whereas, the Insurance Commissioner of New Jersey has previously rejected approval of this filing as being inflationary despite the first physician's assistant being required by law; now therefore be it

RESOLVED, that the Medical-Surgical Plan of New Jersey be requested to resubmit its plan for compensation of first surgical assistants, as required by law, regarding major surgery, and a request be sent to the Insurance Commissioner of New Jersey to urge approval of the MSP recommendation.

The following Substitute Resolution #16 was offered by the sponsor:

Substitute #16

Introduced by **Camden County Medical Society**

Subject: **REIMBURSEMENT OF ASSISTING SURGEON BY BLUE SHIELD OF NEW JERSEY**

Referred to: **Reference Committee "C"**

Whereas, by regulation of the State Board of Medical Examiners of New Jersey ("Rule concerning major surgery," NJAC 13:35-7.1), major surgery shall be performed only by a duly qualified surgeon with a duly qualified assisting physician, or a duly qualified surgical resident; and

Whereas, Blue Shield of New Jersey has developed a rider to reimburse for services of the assisting physician for major surgical procedures when a duly qualified surgical resident is not available; and

Whereas, the Department of Insurance has denied issuance of this coverage for Blue Shield of New Jersey subscribers; now therefore be it

RESOLVED, that Blue Shield of New Jersey be requested to resubmit its proposal for reimbursement for services of assisting physicians for major surgical procedures to the Commissioner of Insurance; and be it further

RESOLVED, that the Medical Society of New Jersey go on record as approving this coverage and request the Commissioner to accept the filing.

Adopted in accordance with the recommendation of the Reference Committee.

REFERENCE COMMITTEE "D"

Ralph J. Cavalier, Jr., M.D., Atlantic
Chairman
William A. Allgair, M.D., Middlesex
Nicholas E. Marchione, M.D., Cumberland
Henry Katz, M.D., Morris
John Winslow, M.D., Essex
William Kamerling, M.D., Camden
Alternate Member

Reports:
Committee on Medical Education
Committee on Emergency Medical Care
Committee on Medicine and Religion

Board of Trustees' Items

FAMILY PRACTICE DEPARTMENT
(Reference Committee "D")

During the Fall of 1979 the Curriculum Committee of the College of Medicine and Dentistry of New Jersey—New Jersey Medical School brought forward a recommendation that in essence indicated that primary care was adequately taught within the School's existing departmental structure, and that a separate department of family medicine was not needed at this time.

Prior to receipt of the report, Stanley S. Bergen, Jr., M.D., President of CMDNJ, urged the Dean of CMDNJ—New Jersey Medical School to hear a presentation of the Academy of Family Practice of New Jersey on this matter. A presentation was made by three members of the Academy and was received enthusiastically by the School's Faculty Council. The matter then was referred back to the Curriculum Committee for rereview and representatives of the Academy were incorporated into the structure to offer their expertise. The Committee now has completed this study and soon will be making recommendations to the Dean and the Faculty Council of CMDNJ—New Jersey Medical School.

Filed in accordance with the recommendation of the Reference Committee.

JOINT PRACTICE COMMITTEE WITH NEW JERSEY STATE NURSES ASSOCIATION
(Reference Committee "D")

The Committee held three meetings during the year. Primarily, discussions concerned the basic nursing education programs in New Jersey.

An agreement was reached in response to Resolution #15 (1979 House of Delegates) that both organizations support the present basic nursing education programs. The Committee was informed that the New Jersey State Nurses Association voted to withdraw support of the "1985 Proposal," which would require, at the entry level, a Bachelor of Science degree to practice nursing in New Jersey.

Various concerns of both groups were discussed, such as: joint practice in a hospital setting, the lack of physician enlightenment concerning joint practice and primary care nursing, and the reimbursement mechanism for nurses' services in the joint practice setting and the primary nursing care setting.

The proposed goals and objectives of the Joint Practice Committee were stressed, and these include:
(1) To address health care delivery issues from the perception of medicine and nursing.
(2) To explore new patterns of practice toward improving patient care, such as: joint practice, primary nursing, and the problem-oriented record.
(3) To serve as a study panel to provide data concerning the attitudes of nurses and physicians about their respective roles and their practice patterns.
(4) To provide a structure between the two professions to examine the increasing diversification of related allied health care personnel.
(5) To address patterns of education of the two professions.
(6) To explore issues arising from the joint practice of nurses and physicians.

The physician attendance at the meetings was less than ideal. However, it is felt that the Committee is an enthusiastic one and should continue into the next year.

Referred back to the Joint Practice Committee. The House of Delegates felt that the Society should support those nurses functioning in its favor.

EMERGENCY MEDICAL SERVICES CRITICAL CARE TASK FORCE REPORTS
(Reference Committee "D")

The Board carefully reviewed the Emergency Medical Services Critical Care Task Force Reports developed by the New Jersey Department of Health. Positions have been developed on each report and forwarded to the Department of Health for consideration.

Filed in accordance with the recommendation of the Reference Committee.

Medical Education

Arthur Bernstein, M.D., Chairman, East Orange

(Reference Committee "D")

During the past year, as required by the House of Delegates, the Committee on Medical Education recommended that those physicians who had not complied with the continuing medical education requirement be dropped from membership in the Medical Society. There were 23 members with delinquent CME credits in 1977 and the memberships of those who did not comply by September 1, 1979 were terminated. In addition, the memberships of 32 with CME credits due in 1978 were terminated, effective December 31, 1979. The county societies have cooperated with the Committee on Medical Education in attempting to reduce the number of terminations and many of these physicians since have reinstated their membership by submitting the necessary credits to the Society.

Through the efforts of the Committee on Medical Education and the volunteer surveyors, 73 hospitals throughout New Jersey are accredited to provide continuing medical education programs. Nineteen surveys were accomplished in 1979, two of them new, and 40 resurveys are due in 1980. The list of accredited hospitals has been published in the Society's *Newsletter.*

At the request of the Committee on Medical Education, the Board of Trustees registered a protest with the Liaison Committee on Continuing Medical Education regarding their procedure of reviewing surveys our Committee had evaluated, thereby prolonging and confusing the accreditation process. As a result of conflicts, the AMA withdrew from the LCCME in July 1979, and it now recognizes state medical associations for the accreditation of intrastate institutions as providers of continuing medical education. However, the New Jersey State Board of Medical Examiners supports the concept of the LCCME as the accrediting body. This ultimately may lead to a problem and will need discussion in the future.

The Committee received a request from Ms. J. Hewitt of New York Medical College to follow up on Dr. Roger's 1969 CME report to see what has transpired since that time. The approval of the Board of Trustees was requested with the provision that the survey letter and her thesis be approved by MSNJ before publication.

Now that continuing medical education has become an accepted fact of life, the Committee has been able to devote itself to another facet of our charge, namely, undergraduate and graduate medical education in the State. Since the Council on Medical Education of the AMA has come up with a revolutionary set of recommendations, the Committee has started discussions with Dr. Bergen and the Deans of the three medical schools to see how these suggestions would or could be implemented. This obviously will be a long-term project of the Committee.

The problems of the foreign medical graduates also will be the future concern of this Committee since there are many issues in medical education presented by these physicians because of their diverse backgrounds. It becomes very clear that as one problem is "solved" many new ones appear on the horizon that will need our consideration.

Since this is the end of my tenure on this Committee, I particularly wish to thank all of the members and consultants for their diligence and hard work and valuable advice. The hospital surveyors have done an excellent job and deserve the kudos of the entire Society. The executive secretaries of the county medical societies have been most diligent and helpful in retaining members. For this we are most grateful. The staff of the Committee has been most valuable in every activity of the Committee and deserves our heartfelt thanks.

Filed in accordance with the recommendation of the Reference Committee.

Emergency Medical Care

Jack R. Karel, M.D., Chairman, Elizabeth

(Reference Committee "D")

The Committee has been active in various aspects of emergency medicine as follows:

EMERGENCY MASS CASUALTY PROGRAM

The Statewide Emergency Mass Casualty Plan was tested by a Command Post Exercise in the Spring of 1979. The incident was a propane gas explosion and fire involving Middlesex and Somerset counties resulting in 150 casualties. All categories of personnel were involved including the hospitals. The test exercise was successful and a live exercise is being planned for the Spring of 1980.

MOBILE INTENSIVE CARE UNIT PROGRAM

This program was approved and recommendation was made that it be continued after the expiration of the five-year pilot program as established by the State Legislature. Subsequently, the latter voted to continue the program on a permanent basis. The Committee also recommended that there be an increase in the number of MICU Hospital Programs in the state.

NATIONAL BURN VICTIM FOUNDATION

The Committee recommended and the Board of Trustees

approved the inclusion in the New Jersey State Emergency Mass Casualty Plan of the National Burn Victim Foundation and the services that would be made available by the Foundation in case there would be excessive numbers of burn victims—the availability of helicopters and the activation of the Foundation's Burn Disaster System.

MARIHUANA AND PHENCYCLIDINE (PSP)

Reports have been received by the NJSDH, since the first notification early in 1979, that some marihuana has been laced with PCP, also known as angel dust. The latter is an extremely dangerous drug which produces psychotic symptoms, such as memory problems, speech difficulties and mood disorders—depression, anxiety and violent behavior. It was reported that on occasion an individual could produce a delayed reaction by consuming a glass of orange juice the following morning. It has been reported in New York that 70 percent of all methadone patients have shown positive tests for PCP use. The Committee recommended, and it was approved by the Board of Trustees, that all hospital emergency departments be notified of this condition and that notification be made by the New Jersey State Department of Health.

NEW JERSEY STATE DEPARTMENT OF HEALTH EMERGENCY MEDICAL SERVICES PROGRAM GUIDES

The State of New Jersey Department of Health desires to establish a statewide system for emergency medical services. In order to develop this program task forces composed of physicians and other allied medical personnel were appointed to develop criteria for the following critical care categories: behavioral emergencies, burns, coronary care, high-risk infants, poisoning, spinal cord injury and trauma. The Committee has reviewed these reports and has made appropriate comments they concern each of the Task Force Reports. A final report will be submitted by the Board of Trustees of the Medical Society of New Jersey.

INTER-AGENCY COMMISSION ON EMERGENCY MEDICAL CARE

Emergency Department Nurse Training Program— The EDNTP conducted by the Inter-Agency Commission completed its second year year of the program on September 30, 1979. It was highly successful. It consisted of 200 hours of education—160 hours of didactic and practical demonstration and 40 hours of inservice training in an emergency department—the later conducted in 15 hospitals throughout the state. The didactic program and practical demonstration were conducted in three schools of nursing. The Mountainside Hospital, Montclair, Saint Francis Medical Center, Trenton and the Helene Fuld School of Nursing, West Jersey Hospital, Camden. One hundred ninety-eight registered nurses working in hospital emergency departments completed the course. The program was funded by the Bureau of Health Manpower, Health Resources Administration, U.S. Public Health Service. A grant application has been submitted to continue the program for a third year in 1980-81.

Clinical Public Relations Seminar—A seminar on Clinical Public Relations was held in April 1980 at the Executive Offices of the Medical Society of New Jersey. The program was concerned primarily with pre-hospital care and its effects on the hospital emergency department.

Mobile Intensive Care Unit Program—The commission supports the increase in the MICU Programs in the state.

New Jersey State Department of Health Emergency Medical Service Program Guides—The Commission has reviewed the Task Force Reports mentioned above. The findings have been referred to the Medical Society of New Jersey.

Filed in accordance with the recommendation of the Reference Committee.

Medicine and Religion

Thomas H. McGlade, M.D., Chairman, Camden

(Reference Committee "D")

The members of the Special Committee on Medicine and Religion were advised February 8, 1980, that due to a steady decline in attendance over the past several years, the Board of Trustees voted to eliminate the Annual Prayer Breakfast during the Annual Meeting.

The Committee will meet on Wednesday, March 12, 1980, at the Executive Offices of the Medical Society of New Jersey to consider other means of implementing the purposes of this Committee.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

#20

Introduced by: **Board of Trustees**

Subject: **COUNTERSIGNING OF MEDICAL ORDERS**

Referred to: **Reference Committee "D"**

Whereas, New Jersey has need for well-educated and competent physicians; and

Whereas, the education of medical students should be enhanced by rules that promote the learning situation; and

Whereas, the protection of the patient is of paramount concern to his/her attending physician during hospitalization, requiring direct supervision of medical students by the licensed attending physician; now therefore be it

RESOLVED, that the Medical Society of New Jersey seek a review by the State Board of Medical Examiners of the status of countersignature of medical orders written by medical students, to insure that medical-order writing remains a valuable component of the educational process, while assuring the protection of the patient by requiring all written orders to be done under the direct supervision of a licensed physician who must countersign the orders before they are carried out or any medications or treatment rendered.

Adopted in accordance with the recommendation of the Reference Committee.

#24 (E)

Introduced by: **Christopher Babigian, M.D., Delegate**
Bergen County Medical Society

Subject: **UNDERGRADUATE CLINICAL TRAINING OF FOREIGN MEDICAL GRADUATES**

Referred to: **Reference Committee "D"**

Whereas, while New Jersey residents have had to go to foreign medical schools to get their medical education; and

Whereas, these are all taxpayers of the State of New Jersey; and

Whereas, the opportunity for them to qualify through hospital work and clinical work in New Jersey has been denied them by the State Board of Higher Education; and

Whereas, many other states allow their residents to do this kind of clinical work in the hospitals in their state; now therefore be it

RESOLVED, that the Medical Society of New Jersey publicly state its objection to ~~this denial~~ **the recent abrupt denial** of undergraduate clinical training to New Jersey students attending foreign medical schools and that it is the opinion of the Medical Society of New Jersey that this decision be reversed and residents of New Jersey should be allowed to do fifth, sixth, seventh, and eighth ~~channel~~ **semester** work in New Jersey hospitals; and be it further

Approved the indicated changes in accordance with the recommendation of the Reference Committee.

RESOLVED, that the Medical Society of New Jersey should publicly declare its feelings in this matter to the New Jersey State Legislators and to the Board of Higher Education and the State Board of Medical Examiners; **and be it further**

RESOLVED, that the New Jersey Board of Higher Education, on application by foreign medical schools, make a determination as to which schools should be approved to send students to New Jersey hospitals. The hospitals being used for such training should be approved by the New Jersey Board of Higher Education.

Adopted as amended by addition of a third "resolved," in accordance with the recommendations of the Reference Committee.

REFERENCE COMMITTEE "E"

Michael R. Ramundo, M.D., Passaic
Chairman
Winton H. Johnson, M.D., Bergen
Carl A. Restivo, M.D., Hudson
Edward A. Schauer, M.D., Monmouth
Robert H. Stackpole, M.D., Union
Gabor Somjen, M.D., Morris
Alternate Member

Reports:
Council on Legislation
Council on Public Relations

Legislation

Daniel J. O'Regan, M.D., Chairman, Jersey City

(Reference Committee "E")

This report presents a summary of the ultimate status of legislative measures of primary concern to the Society in the 1978-79 Legislature.

The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in official bulletins dispatched to State Legislative Keymen and to component societies, and in items published in the *Membership Newsletter* and *The Journal.* The minutes of the meetings of the Board of Trustees include full reports of the Council's actions taken in regular meetings.

The Council on Legislation continues its established policy of inviting an official representative from each specialty society to all Council meetings. Although a notice announcing the date of each of the Council's meetings is sent to all MSNJ's Official Intermediaries with New Jersey Specialty Societies, the attendance of those representatives at the Council meetings remains small. The Council urges that more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields.

The Council on Legislation agreed that in order to fortify our stand on legislative bills and make our position known throughout the Society it be a standing policy to invite the chairman of each Council and Standing Committee to attend the legislative meetings and to give them the right, if they cannot attend, to select a representative.

Of the bills reported to the House from the 198th Legislature the following were signed into law:

ACTIVE SUPPORT

S-777 —Grants civil immunity for peer review activities, including those of professional societies.

S-3026 —Requires school systems to conduct an annual screening of hearing programs in accordance with Department of Education guidelines.

APPROVED

S-3017 —Lowers the statutory level of "groups" from 100 to 50 as was done previously with Blue Cross. In this fashion, parameters of the two plans are similar. It will not permit, however, a group rating formula which produces a rate higher than the community rate.

A-205 —Requires the prescriber to indicate to the pharmacist whether or not the label shall include the name and nature of the drug.

A-1294 A-1295 A-1296 —This three-bill package requires insurers to reimburse patients for services performed by dentists, if such services are covered when provided by physicians. (Blue Shield-Group Contracts-Individual Contracts)

DISAPPROVED

A-1110 A-1111 A-1112 —These bills require Blue Shield, individual health insurance contracts, and group health insurance contracts to require second opinions in all elective surgical cases as a precondition to payment. In addition, when the first and second opinions differ the contract shall provide for a third opinion should the patient so desire one.

The following bills of medical interest were introduced in the 1979 Legislature, but too late to be reported to the 1979 House of Delegates:

S-715 — Skevin—School Nutrition

Provides that only those foods which make a positive contribution to the nutritional needs of the child shall be sold in schools. **APPROVED**

S-3095 — Gagliano—Emergency Medical Services

Provides that the Legislature shall review any regulations adopted by the State Department of Health on the regionalization of emergency medical services and that said regulations may not take effect until 120 days after their submission to the Legislature. **APPROVED**

S-3096 — Skevin—Diethylstilbestrol Related Disorders

Requires the State Department of Health to establish screening programs to locate, diagnose, and refer for proper treatment those who were adversely exposed to DES. The State Department of Health is to file a report with the Legislature one year from the enactment of this legislation. **APPROVED**

S-3106 — Hirkala—Immunity of Review Committees

This bill extends immunities currently applicable to utilization review committees to medical audit, tissue, mortality, and peer review committees of hospitals and long-term care facilities. This legislation is desirable. S-777, however, which also covers state, county, and other professional societies is much more broad and superior to this version. **ACTIVE SUPPORT**

S-3110 — Scardino—Health and Safety of the Elderly

Provides a protection system centered upon reporting by professionals of instances of persons responsible for custodial care of the elderly who have abused or exploited those left in their care.

Reports are to be made to the Office of the Ombudsman for the Institutionalized Elderly upon reasonable cause. The reports are to be confidential and the person making such a report is granted civil and criminal immunity provided he has not acted in bad faith or with malicious purpose. **APPROVED**

S-3126 — Parker—Workmen's Compensation

Increases physician witness fees in Workmen's Compensation hearings from $50 to $300 and from $150 to $900 in the aggregate. **APPROVED**

S-3166 — Russo—Motor Vehicles

Requires the Division of Motor Vehicles to have a space on the operator's license to indicate that the operator suffers from diabetes. **CONDITIONAL APPROVAL,** pending an amendment to include all other potential disabling medical conditions and any other pertinent major-medical information.

S-3176 — Scardino—Emergency Medical Services (MICU)

Extends the Mobile Intensive Care Unit program until December 31, 1979. **APPROVED**

S-3198 — Yates—Health Insurance

Calls for the inclusion of orthomolecular treatment under health insurance contracts, with the exception of groups, when the treatment is prescribed by a licensed physician. **ACTIVE OPPOSITION,** because the treatment is unscientific and because existing regulations already permit reimbursement under general medical treatment where such treatment is valid.

S-3199 — Yates—Health Insurance

Same as S-3198 except it is applicable to group policies. **ACTIVE OPPOSITION,** because the treatment is unscientific and because existing regulations already permit reimbursement under general medical treatment where such treatment is valid.

S-3202 — Yates—Health Insurance

Same as S-3198 and S-3199 except it applies to medical service plans. **ACTIVE OPPOSITION,** because the treatment is unscientific and because existing regulations already permit reimbursement under general medical treatment where such treatment is valid.

S-3210 — Hagedorn—Licensing of Nurse-Midwives

This proposal would restrict the future licensing of midwives to only those applicants who would qualify as "nurse-midwives." Licensing would be through the State Board of Medical Examiners. Permitted acts would be: To prescribe the standards of practice of nurse-midwives under the supervision of a licensed physician.

(1) Such standards shall provide, but not be limited to, that nurse-midwives shall be permitted to:

(a) Assess the women's social, medical and obstetrical history;

(b) Perform the initial physical assessment and obstetrical evaluation;

(c) Order and evaluate standard laboratory diagnostic studies or tests including, but not limited to, CBC, urinalysis, serologic test for syphilis, blood type and Rh factor, sickledex, rubella screening, papanicolaou smear, G.C. culture, T.B. screening, pregnancy test, PPD, anemia work-up, glucose tolerance test, thyroid profile, fetal status, chest x-ray, EKG, Rh antibody, cervical culture, placental culture, nitrazine paper test for diagnosis of rupture of membranes, and such other laboratory diagnostic studies or tests as determined by the committee;

(d) Order nonprescription medication;

(e) Order prescription medication in accordance with approved orders of a licensed physician or upon the consultation and written prescription of a licensed physician;

(f) Provide counseling and teaching appropriate to the needs of the woman, newborn and family;

(g) Refer the woman to appropriate health and social agencies as indicated;

(h) Perform episiotomies and repair a perineal, vaginal or cervical laceration;

(i) Administer local or pudendal anesthesia during the performance of episiotomies and repairing lacerations;

(j) Provide family planning modalities including insertion and removal of IUDs;

(k) Practice nurse-midwifery in hospitals, medical clinics and other related health care facilities, including birthing centers; and

(l) Decide when and if a licensed physician should examine a woman who is under the nurse-midwife's management and care.

(2) Such standards shall provide, but not be limited to, that nurse-midwives shall:

(a) Practice nurse-midwifery under the supervision of and in consultation with a licensed physician who has current practice or training in obstetrics; and

(b) Immediately report or refer to a licensed physician any woman with any medical or obstetrical problem or any woman with complications or deviations from normal in childbirth.

CONDITIONAL APPROVAL, pending deletion of repair of cervical lacerations and insertion and removal of IUDs. (Bill withdrawn per sponsor)

S-3211 — Hagedorn—Licensing of Midwives

Terminates the licensing of any midwife in the future except for renewals of existing licenses. All new applicants must comply with the requirements of S-3210. **APPROVED**

S-3215 — Scardino—Emergency Medical Services (MICU)

Makes the MICU program one of indefinite duration. Provides for annual reports to the legislature on all authorized projects. **ACTION DEFERRED,** pending further information from the Special Committee on Emergency Medical Care re pilot project results, cost effectiveness, and possibility of broadening the scope of the use of the program.

S-3216 — Scardino—Testing of Newborns for Hypothyroidism and Other Diseases

Adds the following mandatory tests to those currently being conducted on newborns—galactosemia, maple sugar urine disease, and homocystinuria. **ACTION DEFERRED,** pending further information from the New Jersey Chapter of the American Academy of Pediatrics and further research of existing statutes.

S-3249 — Russo—Learning Disabilities

Deletes from existing law the term "perceptually impaired" and would substitute therefor "specific learning disability." Specific learning disability is defined as a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations. **NO ACTION**

S-3282 — Bedell—Auto Insurance (No Fault)

Would allow tort claims only when there is "death, serious impairment of body function, or permanent serious disfigurement." Provides for an Advisory Board which shall develop schedules of "reasonable fees for medical services" and also adjudicate disputed fees or questionable treatment. **CONDITIONAL APPROVAL,** pending deletion of Advisory Board established by the Commissioner which will deal with quality assurance measures and which has only two physicians out of five members, plus the deletion of reference to medical care and medical fees.

S-3337 — Errichetti—Medical Education

Appropriates $9,000,000 for land acquisition and construction of "clinical teaching and research" of the College of Medicine and Dentistry of New Jersey osteopathic branch and the allopathic clinical program in Camden. **DISAPPROVED,** because the expenditure of 9 million dollars is not necessary since existing facilities are adequate.

S-3357 — Hamilton—Pilot Program to Provide Case Management Services to the Mentally Ill and Developmentally Disabled

Program emphasis would be directed to residents of nursing homes, rooming houses, and residential health care facilities, but does not rule out services to those in other types of community placements. **NO ACTION**

S-3359 — Friedland—Public General Hospital Assistance

This bill would amend existing law to authorize county and municipal hospitals to offset outpatient expenses with monies currently available, but restricted to inpatient services. **NO ACTION**

S-3390 — Foran—Vital Statistics

Authorizes the correction of birth records based upon sworn testimony of two witnesses. It eliminates the provision calling for documentary evidence when the correction is made prior to the individual attaining the age of majority. **NO ACTION**

A-3215 — Muhler—Nuisance Suits

Allows reasonable attorney fees to successful defendants in the case of any frivolous claims. (Note—this also includes cross claims, third party complaints, and counter claims.) **ACTIVE SUPPORT**

A-3127 — Doyle—Medical and Psychiatric Care in Correctional Institutions

Mandates medical and psychiatric care for inmates in correctional institutions provided it does not necessitate capital construction. **ACTIVE SUPPORT**

A-3128 — Doyle—Voluntary Psychiatric Admissions

Requires patients who have voluntarily admitted themselves to the psychiatric units of general hospitals to submit to treatment (exclusive of electro-shock) during the 72-hour stay. (Creates implied consent). **ACTION DEFERRED,** pending further information from the New Jersey Psychiatric Association and the New Jersey Hospital Association concerning the language of this legislation.

A-3137 — Van Wagner—Amends the Practicing Psychology Licensing Act

Permits school psychologists to engage in private practice. **ACTION DEFERRED,** pending clarification of the language of the bill. The type of testing should indicate whether it would be psychological or psychotherapy.

A-3166 — Deverin—Emergency Medical Services

Provides that the Department of Health may not adopt EMS regulations until 120 days after they have been submitted to both legislative committees on Institutions, Health and Welfare. **ACTIVE SUPPORT**

A-3204 — Herman—Mobile Intensive Care Units

Makes permanent the mobile intensive care unit program which is currently functioning under temporary status. The State Board of Medical Examiners and the State Department of Health will continue to exercise training and regulatory functions. **ACTION DEFERRED,** pending further information from the Special Committee on Emergency Medical Care re pilot project results, cost effectiveness and the possiblity of broadening the scope of the use of the program.

A-3231 — Gewertz—Mobile Intensive Care Units

Would convert the current MICU project from a pilot program into one of ongoing and indefinite duration. **LAW c. 116 ('79)**

A-3245 — Kern—Licensing of Nurse-Midwives

This proposal would restrict the future licensing of midwives to only those applicants who would qualify as "nurse-midwives."

Licensing would be through the State Board of Medical Examiners. Permitted acts would be: To prescribe the standards of practice of nurse-midwives under the supervision of a licensed physician.

(1) Such standards shall provide, but not be limited to, that nurse-midwives shall be permitted to:

(a) Assess the women's social, medical and obstetrical history;

(b) Perform the initial physical assessment and obstetrical evaluation;

(c) Order and evaluate standard laboratory diagnostic studies or tests including, but not limited to, CBC, urinalysis, serologic test for syphilis, blood type and Rh factor, sickledex, rubella screening, papanicolaou smear, G.C. culture, T.B. screening, pregnancy test, PPD, anemia workup, glucose tolerance test, thyroid profile, fetal status, chest x-ray, EKG, Rh anti-body, cervical culture, throat culture, placental culture, nitrazine paper test for diagnosis of rupture of membranes, and such other laboratory diagnostic studies or tests as determined by the committee;

(d) Order nonprescription medication;

(e) Order prescription medication in accordance with approved orders of a licensed physician or upon the consultation and written prescription of a licensed physician;

(f) Provide counseling and teaching appropriate to the needs of the woman, newborn and family;

(g) Refer the woman to appropriate health and social agencies as indicated;

(h) Perform episiotomies and repair a perineal, vaginal or cervical laceration;

(i) Administer local or pudendal anesthesia during the performance of episiotomies and repairing lacerations;

(j) Provide family planning modalities including insertion and removal of IUDs;

(k) Practice nurse-midwifery in hospitals, medical clinics and other related health care facilities, including birthing centers; and

(l) Decide when and if a licensed physician should examine a woman who is under the nurse-midwife's management and care.

(2) Such standards shall provide, but not be limited to, that nurse-midwives shall:

(a) Practice nurse-midwifery under the supervision of and in consultation with a licensed physician who has current practice or training in obstetrics; and

(b) Immediately report or refer to a licensed physician any woman with any medical or obstetrical problem or any woman with complications or deviations from normal in childbirth. **DISAPPROVED,** because this bill advocates a double standard of medical care.

A-3246 — Kern—Licensing of Midwives

Terminates the licensing of any midwife in the future except for renewals of existing licenses. All new applicants must comply with the requirements of A-3245. **APPROVED**

A-3268 — Garvin—Community Mental Health Services

Changes the Community Mental Health Board function to one of advisory or advocacy as opposed to managerial or regulatory. The Department of Human Services would be granted more effective control. Civilian non-medical personnel would constitute the majority of the Board. **ACTIVE OPPOSITION,** because this is unnecessary legislation and of no benefit to the public. Existing boards already grant fair and effective control. Law c. 331 ('79)

A-3317 — Totaro—Medicaid

Creates a hearing aid for the elderly concept. Medicaid would pay 50 percent of the reasonable cost of a hearing aid for those over age 65 with an annual income of less than $9,000. **CONDITIONAL APPROVAL,** pending deletion of "licensed hearing aid dispenser" and the insertion of "licensed physician."

A-3323 — Schwartz—Disclosure of Laboratory Tests

Requires clinical laboratories—upon the written request of the patient—to supply the patient with a copy of the report that the laboratory sent to the physician. **ACTIVE SUPPORT**

A-3343 — Van Wagner—Cardiopulmonary Resuscitation

Requires every employer of ten or more persons to have at least one in every 50 of his employees trained in CPR. **ACTIVE OPPOSITION,** because there is no practical basis for this legislation unless there is an ongoing training program to maintain the skills of CPR.

A-3360 — Van Wagner—Laetrile Therapy

Amends the insurance code to provide individual and group health insurance coverage to laetrile therapy when prescribed by a "doctor of medicine." **ACTIVE OPPOSITION,** because the drug has not been proved therapeutically valid. There has been no documentation of its effectiveness in the treatment of cancer.

A-3361 — Van Wagner—Laetrile Therapy

Same as A-3360.

A-3383 — Bornheimer—No Fault Auto Insurance

Same as S-3282

A-3407 — Visotcky—Statute of Limitations

Creates a positive Statute of Limitations in New Jersey which would be two years from the date of the act or two years from the date the act should have been discovered, but in no event greater than ten years. **ACTIVE SUPPORT**

A-3463 — Visotcky—Podiatry

Permits the Department of Higher Education to make capitation payments to out-of-state podiatry schools for New Jersey residents to assure New Jersey of a future supply of podiatrists. **DISAPPROVED,** because the need for this legislation has not been demonstrated and its cost would be an unnecessary burden on the taxpayers of New Jersey.

A-3489 — Herman—No Fault Auto Insurance

This bill places a $100,000 limit on medical expense benefits. Establishes an Advisory Committee to assist the Commissioner of Insurance in establishing reimbursement schedules for medical and hospital services, (the rates of the Hospital Rate Setting Commission would be used). Those convicted of driving under the influence would not be able to assert claims. The current $200 medical expense threshold would be retained for claims under $10,000. A verbal threshold would be used for claims exceeding $10,000. (Note: this could present a difficulty, since current Rules of Court do not allow specification of damages in pleadings. Apparently, the technique used in Federal cases of alleging simply that "damages exceed $10,000" would be used. **CONDITIONAL APPROVAL,** pending deletion of Advisory Board established by the Commissioner which will deal with quality assurance measures and which has only two physicians out of five members, plus the deletion of reference to medical care and medical fees. (See S-3282—"New Jersey Automobile Reparation Act")

A-3507 — Stewart—Radiologic Technicians

Transfers the x-ray technician licensing board from the operative effects of Title 45 into Title 26. **NO ACTION**

A-3555 — Hurley—Blood Collection and Replacement

All blood banks would be required to engage in reciprocal exchange programs without regard to geographical location or organizational affiliation. The assessment of non-replacement fees is prohibited. The New Jersey Public Health Council shall regulate the system. **ACTION DEFERRED,** pending further investigation by the Medical Society's Council on Public Health.

Filed with commendation in accordance with the recommendation of the Reference Committee. Regarding the licensing of nurse-midwives, the Reference Committee supports the effort for supervision and monitoring of their activities by physicians.

Supplemental Report #1

(Reference Committee "E")

At 12 o'clock noon, Tuesday, January 8, 1980, the Senate and General Assembly met for the organization of the first annual session of the 199th New Jersey State Legislature. As the Legislature is presently constituted, the Senate has a total of 40 members consisting of 13 Republicans and 27 Democrats. The Assembly has a total of 80 members consisting of 36 Republicans and 44 Democrats. By means of official legislative bulletins, the Society's official positions on all current State Legislation are regularly called to the attention of legislators as well as of component societies, cooperating agencies, county keymen, and county society secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation:

ACTIVE SUPPORT	All-out support of the measure
ACTIVE OPPOSITION	All-out opposition for the measure
CONDITIONAL APPROVAL	To indicate that the approval of the Society is conditional subject to the elimination of the unsatisfactory elements of the bill that are pointed out.
APPROVAL	Commended as satisfactory, but not actively supported
DISAPPROVAL	Rejected as unsatisfactory, but not actively opposed

CURRENT STATE LEGISLATION

The Council offers this Supplemental Report #1 covering items dealt with since the compilation of its Annual Report.

S-11 Weiss—Products Liability of Pharmaceutical Products

Requires all drug manufacturers in New Jersey to carry (a) products liability insurance according to minimum standards of the Insurance Commissioner, (b) provide products liability indemnity protection to each pharmacist retailing their products. **CONDITIONAL APPROVAL,** pending the following amendment is added to the bill: "c. Provide products liability indemnity protection to each physician prescribing or dispensing their products."

S-14 Weiss—Consent to Elective Surgery

Requires physicians to secure specific written consent to elective surgical procedures which shall indicate the operating surgeon and identify any other participating physicians. The primary surgeon must be in continuous attendance unless an emergency occurs in which event his absence shall be noted in the operative record. The operative record which must be kept shall indicate the name, position, and duties of each person in attendance at such operation. This record must be available for at least one year at both the hospital and the physician's office and available for the patient's inspection and reproduction. **DISAPPROVED WITH ACTIVE OPPOSITION IF BILLS MOVES,** because this legislation is impractical and unworkable and would negate teaching programs in New Jersey. Current record-keeping systems are adequate.

S-34 Cafiero—Comparative Negligence

This would amend existing statutes in order to overcome case law which held that in the case of multiple defendants, if the plaintiff's negligence exceeded that of any one of the defendants there would be a bar to recovery. **NO ACTION**

S-44 Scardino—Community Mental Health Programs

Amends existing statutes by emphasizing the State's intent to encourage the development of community mental health programs. **NO ACTION**

S-48 Scardino—Department of Public Advocate

Restructures the Division of Mental Health Advocacy within the Department to create a Division of Mental Health Legal Counseling and Assistance which shall be staffed by multi-disciplined personnel. Jurisdiction is all encompassing and relates to counseling, advising, and representing patients on all admissions, confinements, or retainments in mental health facilities, transfers, treatment, etc. The Division also will have the right to inspect and visit, at any time, any center, clinic, hospital, or facility for patients who are mentally disordered. **ACTION DEFERRED,** pending further information from the Council on Mental Health.

S-49 Scardino—Mental Treatment Standards Committee and Patient Review Board

The proposed committee will consist of ten New Jersey residents: one psychiatric social worker; one psychiatrist; one psychiatric nurse; the Director of the Division of Mental Health and Hospitals; one administrator of a community mental health facility, and one licensed psychologist; one representative from the Department of Health; one representative from Medicaid; one representative from the Department of Education; and one representative who was a patient at a county or state psychiatric facility.

The Committee shall prepare a recommended "Manual of Adequate Standards for Treatment of the Mentally Ill in State Mental Institutions." The standards recommended by the Committee shall be expressed in as objective terms as possible.

This also has created a Patient Treatment Review Board, consisting of one psychiatrist, one non-psychiatrist M.D., one licensed psychologist, one psychiatric R.N., and one licensed attorney. The Board shall review patient complaints and recommend such action as may be necessary to compel adequate treatment. **ACTIVE OPPOSITION,** because the Director of the Division of Mental Health and Hospitals should not be a member of the Mental Treatment Standards Committee. Funds are not specified to implement the program. Arbitrary decisions are allowed and the Committee has no way to enforce its own recommendations. Above all, it should be noted that adequate review mechanisms already exist and function well.

S-78 Scardino—Testing of Newborns for Hypothyroidism and Other Diseases

Adds the following mandatory tests to those currently being conducted on newborns—galactosemia, maple sugar urine disease, and homocystinuria. **ACTION DEFERRED,** pending further information from the New Jersey Chapter of the American Academy of Pediatrics.

S-89 Dorsey—Tort Immunity (Municipal Services)

Extends governmental immunities to private physicians performing services for public entities whether as volunteers or independent contractors. **APPROVED**

S-107 Bedell—Reimbursement for Nursing Services (MSP)

Permits policies at the option of the subscriber to provide direct reimbursement to nurses for nursing care if the nurse is not paid a salary by any health care provider for the duties so performed. **NO ACTION**

S-108 Bedell—Reimbursement for Nursing Services (Individual Health Insurance Coverage)

Same as **S-107** except it applies to individual commercial insurance contract benefits. **NO ACTION**

S-109 Bedell—Reimbursement for Nursing Services (Group Health Insurance)

Same as **S-107** except it is applicable to group health insurance contracts. **NO ACTION**

S-153 Zane—Civil Immunity

Provides immunity from civil suit for the Medical Vision Advisory Panel and persons providing reports and recommendations with respect to a licensee's ability to safely operate a motor vehicle. **APPROVED**

S-205 Feldman—Data Privacy

A State version of the Federal Privacy Act, this bill grants individuals access to their personal information held in State government files. At the same time, it obligates the State to prevent the misuse of private or confidential information and makes the government subject to civil suit. An information data system would be created to classify the data being retained and stored by the State. **APPROVED**

S-217 Feldman—Cardiopulmonary Resuscitation

Requires recreational and athletic facilities to have at least one CPR-trained employee on premises at all regular operating hours. **NO ACTION**

S-251 Russo—Motor Vehicles Driver's License

Requires the Division of Motor Vehicles to have a space on the

operator's license to indicate that the operator suffers from diabetes. **ACTIVE OPPOSTION,** because it neither advances the health interests of patients with diabetes nor would it lead to any recognizable results in highway safety.

S-275 Russo—Cardiopulmonary Resuscitation

Mandates a three-hour course of instruction in CPR in order to enter the final year of high school. **DISAPPROVED,** because of the degradation of knowledge and the possible harmful effects to the public which would outweigh the potential benefit of the bill.

S-299 Yates—Health Insurance (Orthomolecular Treatment)

Calls for the inclusion of orthomolecular treatment under health insurance contracts with the exception of groups when the treatment is prescribed by a licensed physician. **ACTIVE OPPOSITION,** because the treatment is unscientific and because existing regulations permit reimbursement when medically justified.

S-300 Yates—Health Insurance

Same as **S-299** except it is applicable to group policies. **ACTIVE OPPOSITION,** because the treatment is unscientific and because existing regulations permit reimbursement when medically justified.

S-301 Yates—Health Insurance

Same as **S-299** and **S-300** except it is applicable to medical service plans. **ACTIVE OPPOSITION,** because the treatment is unscientific and because existing regulations permit reimbursement when medically justified.

S-310 Dodd—Catastrophic Health Insurance

Creates a catastrophic health insurance fund to reimburse individuals for catastrophic costs incurred because of injury or illness. The fund is to be initially capitalized by the State which would then bill private carriers for their insureds. The carriers then would be permitted to recapture losses by placing surcharges on their policies. All of the mechanism is to be monitored by the Insurance Department and administered via a "Health Insurance Underwriting Association." **DISAPPROVED,** although MSNJ approves the concept of catastrophic health insurance, this bill would change the insurance companies into fiscal intermediaries, is not sound fiscally, and would prove counter productive.

S-319 Dodd—Medicaid (Skilled Nursing Facility Beds)

Would allow general hospitals to designate a number of its beds as SNF beds for Medicaid eligibles. There would be an automatic reversion of the beds on December 31, 1981. **NO ACTION**

S-352 Hagedorn—Involuntary Commitments

Restructures existing laws to provide that:

(1) The Boards of Freeholders shall designate one or more screening centers within their counties or on an inter-county basis as the Department of Human Services may approve,

(2) The screening service shall provide examinations, diagnoses evaluation, and emergency treatment in accordance with departmental regulations.

(3) Involuntary commitments are to be certified to by two psychiatrists, or one psychiatrist and one licensed physician, or a psychiatrist and a psychologist.

(4) The screening or commitment process is to be initiated by a sworn document signed by an immediate family member, next-of-kin, physician, psychiatrist, county medical examiner, social worker, police official, county prosecutor, or a county or muncipal welfare director.

(5) Screening services shall hold persons determined to be dangerous for no more than seventy-two hours before the involuntary commitment mechanism must be complied with.

(6) Patients being admitted to screening centers or institutions have a detailed list of rights including the immediate right to counsel.

ACTIVE OPPOSITION, because this legislation would be too costly and would not improve the present mechanism.

S-390 Russo—Determination of Death

Defines death as the irreversible cessation of vital brain function accompanied or preceded by the cessation of natural respiratory and circulatory functions. Death occurs when brain functions cease unless natural respiratory and circulatory functions shall have ceased earlier. **APPROVED**

S-396 Russo—Smoking in Hospitals

Requires hospital governing boards to regulate smoking within hospitals. Visitors and staff shall smoke only in designated areas and not in the presence of patients. Patients shall be assigned rooms according to smoking preferences. **APPROVED**

S-398 Russo—Motor Vehicle Implied Consent

Would extend the implied consent law to include the taking of blood and urine samples for alcohol or drug determinations. Refusal to permit the sampling would carry the same penalty as refusal of the breath analysis test. **APPROVED**

S-443 Lipman—Minor's Consent to Treatment

Amends existing law to allow minors who have been sexually assaulted (in the judgment of a treating physician) to consent to medical and surgical treatment. **APPROVED**

S-444 Lipman—Hereditary Disorders Act

This bill requires the Department of Health to set up a program of assistance for New Jersey citizens who suffer from hereditary disorders such as Cooley's anemia, cystic fibrosis, sickle cell anemia, galactosemia, hemophilia and Tay-Sachs disease. The program would include the development of:

1. Standards for detecting hereditary disorders.
2. Voluntary testing and genetic counseling services.
3. Laboratory services.
4. An educational program concerning hereditary disorders.
5. Curriculum guidelines (in cooperation with the Commissioner of Education) concerning the "nature, detection, prevention, and treatment of hereditary disorders"; and
6. Efforts (in cooperation with the Commissioner of Insurance) to eliminate "arbitrary and unreasonable discrimination against carriers or victims" of these disorders in insurance policies.

DISAPPROVED, because present programs adequately cover these disorders.

SCR-22 Hagedorn—Medicaid Study Commission

Creates a 12-member Commission to study Medicaid abuse and evaluate the overall program, including the development of alternative methods providing necessary and appropriate medical assistance to the needy. **NO ACTION**

A-100 Gallo—Automobile Reparation Reform Act

Raises current ceilings under the bodily injury portion of the no-fault law. Places a limit on medical expense coverage to aggregate of $50,000. The Commissioner of Insurance is authorized to promulgate a schedule of the types of treatment and reasonable fees for medical services for the most common forms of injuries arising out of motor vehicle accidents. In this regard, the Commissioner is to be assisted by a panel of medical, legal, and insurance experts appointed by him. **ACTIVE OPPOSITION,** because there are existing organizations in New Jersey that can promulgate a schedule for the types of treatment as called for in the bill, i.e., PSROs and the New Jersey Foundation for Health Care Evaluation.

A-161 Kavanaugh—Controlled Substances Therapeutic Research

Grants to the Department of Health, the ability to regulate and control the therapeutic research of marijuana in conformity with the Federal Drug Enforcement Administration (FDEA), Federal Drug Administration (FDA), and National Institute on Drug Abuse Protocol. **NO ACTION**

A-168 Kavanaugh—Driving Privileges (Epileptiform Seizures)

Extends existing law to provide for a semi-annual certification by the attending physician that the patient is seizure free. After two years the certification is due on an annual basis. **ACTION DEFERRED,** pending certain amendments by the Division of Motor Vehicles.

A-171 Lesniak—Informed Consent for Elective Surgery

Requires physicians to secure specific written consent to elective surgical procedures which shall indicate the operating surgeon and identify any other participating physicians. The primary surgeon must be in continuous attendance unless an emergency occurs, in which event his absence shall be noted in the operative record. The operative record which must be kept shall indicate the name, position, and duties of each person in attendance at such operation. This record must be available for at least one year at both the hospital and the physician's office and available for the patient's inspection and reproduction. **DISAPPROVED WITH ACTIVE OPPOSITION IF BILL MOVES,** because this legislation is impractical and unworkable and would negate teaching programs in New Jersey. Current record-keeping systems are adequate.

A-212 Matthew—Group Health Insurance

Would allow insurers to compensate marriage counselors acting within the scope of their license. **DISAPPROVED,** because the service provided is not a health care service.

A-232 McManimon—Acupuncture

Recognizes acupuncture as an experimental medical modality which only can be utilized by a physician who has had special training or a lay acupuncturist employed by and working under the direction of a certified physician. Initial history and physical must be done by a licensed physician. Non-physician acupuncturists must be salaried employees of physicians, or of a center supervised by a licensed physician. **NO ACTION**

A-249 Otlowski—Involuntary Commitment

The purpose of this bill is as follows:

1. To modernize and simplify involuntary hospitalization procedures.
2. To provide explicit civil rights protection for those involuntarily committed.
3. To facilitate appropriate medical diagnosis, treatment, and care of the mentally ill.
4. To provide reasonable and feasible emergency evaluation and emergency admission procedures.
5. To define more clearly those dangerous mentally ill subject to involuntary hospitalization while excluding criminal or antisocial behaviors as a basis for such hospitalization.
6. To provide for adequate and continuing court review.
7. To recognize the balance between the need for provision of appropriate medical care and the need for relevant legal safeguards.
APPROVED

A-311 Visotcky—Employment of X-Ray Technicians

Makes it a crime of the fourth degree to knowingly or negligently employ an x-ray technician that does not possess a valid certificate. **APPROVED** (N.B. bill, as amended, complies with MSNJ position)

A-315 Visotcky—Pharmaceutical Assistance for the Aged

Amends existing law to limit the permissible amount of medication for reimbursement purposes to a 30-day supply. Except for insulin, insulin syringes, and needles which may be dispensed in a 100-day supply. **BILL WITHDRAWN**

A-321 Visotcky—Statute of Limitations

Creates a positive Statute of Limitations in New Jersey which would be two years from the date of the act or two years from the date the act should have been discovered, but in no event greater than ten years. **ACTIVE SUPPORT**

A-322 Visotcky—Podiatry

Permits the Department of Higher Education to make capitation payments to out-of-state podiatry schools for New Jersey residents to assure New Jersey of a future supply of podiatrists. **ACTIVE OPPOSITION,** because the need for this legislation has not been demonstrated and its cost would be an unnecessary burden on the taxpayers of New Jersey.

A-367 Doyle—Workmen's Compensation (Free Choice of Physician)

Allows injured workers to select, upon notice to their employer, their own physician or hospital for the treatment of covered injuries. **APPROVED**

A-394 Orechio—Cardio-Pulmonary Resuscitation

Requires school boards to offer CPR as a mandatory course for all high school students. **DISAPPROVED,** because of the degradation of knowledge and the possible harmful effects to the public which would outweigh the potential benefit of the bill.

A-414 Paolella—Motor Vehicle Operation

Would permit persons with 20/50-20/70 vision to be licensed for daylight driving. Those with 20/60-20/70 could be licensed, if certified to, by an optometrist or ophthalmologist. Current regulations preclude such persons from licensure. **ACTIVE OPPOSITION,** because the established laws are for the safety and benefit of the driving public. Persons with such diminished vision should not be driving cars and the restriction to daylight hours will not in and of itself address the issue of diminished vision, i.e., overcast weather, rain, snow, etc.

A-423 Karcher—Peer Review Immunity

Expands current immunity statute to afford confidentiality of data in possession of peer review committees. **ACTIVE SUPPORT**

Filed in accordance witht the recommendation of the Reference Committee.

Supplemental Report #2

(Reference Committee "E")

CURRENT STATE LEGISLATION

The Council offers this Supplemental Report #2 covering items dealt with since the compilation of its Supplemental Report #1.

S-382 Russo, et al—Damages for Wrongful Death of Minors

This bill would allow computation of factors other than pecuniary loss in the wrongful death of minors with said damages to be limited to $100,000. (Current case law does not recognize such a compensable event unless the estate of the minor proved actual lost wages or income-producing activity.) If enacted, this bill could have the effect of escalating personal injury liability rates. **DISAPPROVED,** because only damages established by proof should be subject to award.

S-693 Parker—Breath and Blood Determinations—Persons Suspected of Driving Under the Influence of Alcohol or Other Intoxicating Drugs

Grants immunity to physicians who take samples or make tests at the request of police when done in a medically acceptable manner, but not forcibly and against physical resistance. **NO ACTION** (In view of our position of approval on S-398)

S-746 Hirkala—Immunity of Review Committees

Extends confidentiality to data in the possession of hospital peer review committees. **ACTIVE SUPPORT**

S-747 Hirkala—Civil Immunity of Review Committees

Extends civil immunity to hospital board members when exercising good faith in considering the appointment or dismissal of medical staff applicants. **ACTIVE SUPPORT**

S-809 Skevin—Radiology Services

Permits radiologists to bill patients for x-ray interpretations for amounts that are not covered under the person's hospital service contract. **ACTION DEFERRED,** pending further information from the Radiological Society of New Jersey.

S-811 Skevin—Cigarette Tax Act

Taxes cigarettes 1¢ per package to finance cancer research. **NO ACTION**

S-813 Skevin, et al—Cancer Detection

Creates within the Department of Health a cancer detection program to include detection and treatment clinics, research, and training programs in cancer detection. Note: Our condition is incorporated in lines 8-11 of this bill. **NO ACTION**

S-814 Skevin, et al—Cancer Control Act

Creates in the Department of Environmental Protection an Advisory Cancer Control Council which shall consist of 15 members, three of whom are ex-officio cabinet officers and 12 gubernatorial appointees. The Council shall coordinate the activities of the Departments of Health, Labor and Industry and Environmental Protection to control the release of carcinogens into the environment and the production, manufacture, sale, labeling, and use of products containing carcinogens. **NO ACTION**

S-830 Skevin—Controlled Dangerous Substances Therapeutic Research and Treatment

Creates a Therapeutic Research and Treatment program within the Department of Health that would authorize the experimental use of marihuana and other drugs under Federal protocol. MSNJ would recommend the appointment of physicians to the review board that would be established. **NO ACTION**

S-865 Orechio—Electrologists Licensing Act

Authorizes the State Board of Medical Examiners to license electrologists. An electrologist is "a person who professionally removes hair from apparently normal skin of the human body by electrical, electronic, or other technical, scientific methods approved by the Board." The advisory board is to consist of three electrologists and three medical doctors, preferably dermatologists. **ACTION DEFERRED,** pending further information from the New Jersey Dermatological Society

S-904 Russo—Physician Advertising

Permits physicians to place their names on signs or directory posts within reasonable proximity to the building wherein their office is located. **NO ACTION**

S-943 Feldman—Cardio-pulmonary Resuscitation Training (CPR)

This bill permits cardio-pulmonary resuscitation training (CPR) for all high school students, under rules and regulations developed by the Department of Education in consultation with the Department of Health. Students whose parents or guardian objects on the grounds of religious beliefs would be exempt. **NO ACTION**

S-954 Scardino, et al—State Medical Examiner Act

Amends existing statutes to include as a medical examiner case the "deaths of children under three years of age where the suspected cause is sudden infant death syndrome." **APPROVED**

S-1051 Caulfield, et al—Medical Education Facilities Fund

Appropriates $2.268 million for the purpose of constructing a cancer education, research, and treatment center at CMDNJ (Newark). **NO ACTION**

S-1052 Hamilton, et al—An Act Concerning Podiatrists

Redefines the terms "physician and/or surgeon" to include, unless otherwise intended,—podiatrists. Does not carry with it an extension of podiatric license except that podiatrists could direct the work of "paraprofessionals" such as physiotherapists and nurses. **ACTIVE OPPOSITION,** because the bill would be confusing to the public since it represents podiatrists as something they are not, e.g., physicians and surgeons.

S-1089 Friedland, et al—Payments of Attorneys Fees in Civil Suits

Allows the Courts to award defense costs and attorney's fees to successful defendants in situations where the court finds a professional liability claim or counterclaim to have been frivolous or repetitious or barred by the Statute of Limitations. **ACTIVE SUPPORT**

A-485 Schwartz—Disclosure of Laboratory Tests

Requires clinical laboratories—upon written request of the patient —to supply the patient with a copy of the report that the laboratory sent to the physician. **ACTIVE SUPPORT**

A-486 Schwartz, et al—Establishment of a Hereditary Disorders Program

This bill requires the Department of Health to set up a program of assistance for New Jersey citizens who suffer from hereditary disorders such as Cooley's anemia, cystic fibrosis, sickle cell anemia, galactosemia, hemophilia and Tay Sachs disease. The program would include the development of: 1) standards for detecting hereditary disorders; 2) voluntary testing and genetic counseling services; 3) laboratory services; 4) an educational program concerning hereditary disorders; 5) curriculum guidelines (in cooperation with the Commissioner of Education) concerning the "nature, detection, prevention and treatment of hereditary disorders"; and 6) efforts (in cooperation with the Commissioner of Insurance) to eliminate "arbitrary and unreasonable discrimination against carriers or victims" of these disorders in insurance policies. **DISAPPROVED,** because there are many other hereditary disorders that should also be included in this legislation.

A-498 Weidel—Cigarette Tax

Imposes a 10¢ per pack tax on cigarettes to finance cancer research. **NO ACTION**

A-561 Kern, et al—Licensing of Nurse-Midwives

This proposal would restrict the future licensing of midwives to only those applicants that would qualify as "nurse-midwives." Licensing would be through the State Board of Medical Examiners. Permitted acts would be: To prescribe the standards of practice of nurse-midwives under the supervision of a licensed physician. (Physical presence of the physician is not required)

(1) Such standards shall provide, but not be limited to, that nurse-midwives shall be permitted to:

(a) Assess the woman's social, medical and obstetrical history;

(b) Perform the initial physical assessment and obstetrical evaluation;

(c) Order and evaluate standard laboratory diagnostic studies or tests including, but not limited to, CBC, urinalysis, serologic test for syphilis, blood type and Rh factor, sickledex, rubella screening, papanicolaou smear, G.C. culture, T.B. screening, pregnancy test, PPD, anemia workup, glucose tolerance test, thyroid profile, fetal status, chest x-ray, EKG, Rh antibody, cervical culture, throat culture, placental culture, nitrazine paper test for diagnosis of rupture of membranes, and such other laboratory diagnostic studies or tests as determined by the committee;

(d) Order nonprescription medication;

(e) Order prescription medication in accordance with approved orders of a licensed physician or upon the consultation and written prescription of a licensed physician;

(f) Provide counseling and teaching appropriate to the needs of the woman, newborn and family;

(g) Refer the woman to appropriate health and social agencies as indicated;

(h) Perform episiotomies and repair a perineal, vaginal or cervical laceration;

(i) Administer local or pudendal anesthesia during the performance of episiotomies and repairing lacerations;

(j) Provide family planning modalities including insertion and removal of IUDs;

(k) Practice nurse-midwifery in hospitals, medical clinics and other related health care facilities, including birthing centers; and

(l) Decide when and if a licensed physician should examine a woman who is under the nurse-midwife's management and care.

(2) Such standards shall provide, but not be limited to, that nurse-midwives shall:

(a) Practice nurse-midwifery under the supervision of and in consultation with a licensed physician who has current practice or training in obstetrics; and

(b) Immediately report or refer to a licensed physician any woman with any medical or obstetrical problem or any woman with complications or deviations from normal in childbirth.

ACTIVE OPPOSITION, because this legislation advocates a double standard of medical care and fosters the unlicensed practice of medicine.

A-562 Kern, et al.—Licensing of Midwives

Companion bill to A-561 (Techanical Amendment) **ACTIVE OPPOSITION,** because existing statute and proposed regulations fully address the needs of the patients of New Jersey.

A-566 Deverin—Amends the Automobile Reparation Reform Act

Amends the Automobile Reparation Reform Act in accordance with the Legislative Study Commission Report. Calls for the creation of review boards to establish schedules of reasonable medical fees. **ACTIVE OPPOSITION,** because the Council feels that it is unnecessary for the Commissioner of Insurance to promulgate a schedule of fees; also there are existing mechanisms for evaluating the appropriateness of medical care such as PSROs.

A-602 Herman—Motor Vehicle Implied Consent

Would extend the implied consent law to include the taking of blood and urine samples for alcohol or drug determinations. Refusal to permit the sampling would carry the same penalty as refusal of the breath analysis test. **NO ACTION** (In view of our position of approval on S-398)

A-603 Herman—No Fault Auto Insurance

This bill places a $100,000 limit on medical expense benefits. Establishes an Advisory Committee to assist the Commissioner of Insurance in establishing reimbursement schedules for medical and hospital services, (the rates of the Hospital Rate Setting Commission would be used). Those convicted of driving under the influence would not be able to assert claims. The current $200 medical expense threshold would be retained for claims under $10,000. A verbal threshold would be used for claims exceeding $10,000. (Note: this could present a difficulty, since current Rules of Court do not allow specification of damages in pleadings. Apparently, the technique used in Federal cases of alleging simply that "damages exceed $10,000" would be used. **ACTIVE OPPOSITION,** because limitations placed on expense benefits, during this inflationary period, would not be reasonable. Bill is considered discriminatory and could lead to the rationing of health care.

A-607 Herman—Medicaid

Extends Medicaid eligibility to those currently not eligible if they encounter a catastrophic illness which means "any illness or injury requiring inpatient care in a hospital or skilled nursing facility, the costs of which exceed 25% of the person's annual net income in excess of the applicable categorical assistance eligibility level, whichever is less." **NO ACTION**

A-617 Schuck—Charitable Institutions

Persons serving without compensation on the boards of charitable institutions would be immune from liability for acts or omissions arising from the discharge of their duties. **NO ACTION**

A-676 Deverin, et al—Medicaid

Expands Medicaid coverage to medically needy persons who are ineligible under the current law because their incomes are too high. **NO ACTION**

A-744 Karcher—Revocation of Medical Licenses

Provides for the mandatory revocation of licenses to practice whenever the licensee has violated Federal or State narcotic drug laws. **ACTIVE OPPOSITION,** because many violations are technical in nature and do not warrant revocation of a license, but a lesser penalty. Current law allows the State Board of Medical Examiners to impose a suspension or revocation according to the gravity of the offense and is preferable to this bill.

A-769 Deverin—Respiratory Therapist Act

Provides for the licensing and regulation of respiratory therapists and technicians under the auspices of the State Board of Medical Examiners. Provision of services other than under the direction or supervision of a physician shall be cause for revocation of licensure. **ACTIVE OPPOSITION,** Council feels that respiratory therapists and technicians should function under the supervision of physicians and should follow the rules and regulations of the hospital medical staff.

A-771 Deverin—Arrests of Apparently Intoxicated Persons

Requires police officers when making arrests of apparently intoxicated persons to examine those persons for the presence of medic-alert bracelets or other forms of identification. **APPROVED**

A-774 Deverin—Occupational Therapy Licensing Act

Creates a new class of licensed practitioners who would function independently and would be permitted to perform such services as the design, fabrication, and application of splints; sensorimotor activities; the use of specifically designed crafts, guidance in the selection and use of adaptive equipment, therapeutic activities to enhance functional performance; prevocational evaluation and training, and consultation concerning the adoption of physical environments for the handicapped. The State Board of Medical Examiners will exercise jurisdiction. **DISAPPROVED,** because this bill lacks the proper physician direction.

A-819 Bassano, et al.—Controlled Dangerous Substances Research

Creates a research program within the State Department of Health. Patients not responding to conventional therapy will be allowed into the program. Drugs currently on the Federal Drug Administration experimental list, i.e., marihuana, etc., will be utilized under Federal guidelines. The MSNJ will be given an active role, i.e., making recommendations to the Commissioner of Health for appointment to the Therapeutic Research and Treatment Qualification Review Board. **NO ACTION**

A-859 Curran, et al.—Death With Dignity Act

Would permit adults to direct that in the event of a terminal illness no extraordinary maintenance medical treatment is to be used to prolong life. **APPROVED**

A-878 Hurley, et al.—Blood Collection and Replacement

All blood banks would be required to engage in reciprocal exchange programs without regard to geographical location or organizational affiliation. The assessment of non-replacement fees is prohibited. The New Jersey Public Health Council shall regulate the system. **DISAPPROVED WITH ACTIVE OPPOSITION IF THE BILL MOVES,** because MSNJ House of Delegates' policy mandates pluralism in the recruitment of donors and this bill does not have such a provision.

A-882 Hurley, et al.—Withholding or Withdrawing of Life-Sustaining Procedures in Event of Terminal Illness

Empowers adults to execute a statutory form of directive to their physicians providing for the withholding or withdrawing of life-sustaining procedures during a terminal illness. The directive would be valid for five years and provides immunity for physicians and other providers complying with such a directive. "Life sustaining" means a modality or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which would serve only to prolong artificially the moment of death, where in the judgment of the attending physician death is imminent whether or not such procedures are utilized. It does not include "the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain." **APPROVED**

A-887 Hurley, et al.—Motor Vehicles

Provides for implied consent to the taking of blood and urine samples for chemical analysis to determine drug content. Samples may not be taken forcibly and against the physical resistance of the person being arrested. **APPROVED**

A-923 Herman—Prescription Drugs

Amends existing law to permit patients to possess a ten days' supply of a controlled dangerous substance in a container other than the original provided the patient carries with him a writing provided by his physician detailing the name and address of the dispensing practitioner, the prescription record identification number, the name, address, and registration number of the prescriber, the name of the substance, and the directions for its use. **APPROVED**

A-928 Stockman, et al.—An Act Prohibiting Demands for Payment as a Condition Precedent for Completion of Insurance Forms

Prohibits physicians from demanding payment from a patient for services rendered prior to completion of a medical claim form in connection with an insurance policy or plan. **ACTION DEFERRED** —pending further information from the New Jersey Society of Anesthesiologists and other specialty societies that may be involved.

A-962 Orechio—Misrepresentation of Medical Reports

Makes it a crime of the third degree for a physician to intentionally falsify a medical report which is used in negotiations, administrative or judicial proceedings. **(CURRENT LAW)**

A-966 Stewart—Radiation Protection Act

Calls for the Departments of Health, Energy, Transportation, Environmental Protection and the State Police to develop a Radiation Emergency Response Plan. **(CURRENT LAW)**

A-1031 Fortunato—Special Hospitals Emergency Services

All special hospitals would be required to provide full time emergency services coverage. **ACTIVE OPPOSITION,** because the context of the bill is not clearly defined, i.e., (What is meant by resident physician?, etc.) plus the cost implication would defeat the purpose of the bill. There are twenty-two hospitals licensed as "special hospitals" within the State that have arrangements for a physician to be on call at all times, but they are not physically present.

A-1140 Schuck—Medical Education Facilities Fund

Appropriates $9 Million for CMDNJ (Camden) land acquisition and construction. **(CURRENT LAW)**

A-1155 Lesniak—Parental Notification Prior to the Performance of an Abortion

Requires parental notice prior to the performance of an elective abortion on an unemancipated minor. **ACTIVE OPPOSITION,** because this bill is an inconsistency of existing law, e.g., a pregnant woman has already been declared an emancipated minor under Title IX of the New Jersey Statutes.

A-1184 Orechio—Eye and Ear Examinations of School Children

Mandates boards of education to employ one or more optometrists to be known as the "school vision examiners" and one or more physicians to be known as "school hearing examiners." (The hearing examiners also may be the medical inspectors) **ACTION DEFERRED,** pending further information from the Academy of Ophthalmology and Otolaryngology.

A-1205 Brown—Medical Education Facilities Fund

Appropriates $2.268 million for the purpose of constructing a cancer education, research, and treatment center at CMDNJ (Newark). **NO ACTION**

A-1247 Orechio—An Act Prohibiting Certain Physicians' Charges

Makes it unlawful for a physician, rendering medical services, to charge certain persons more than their health insurance contracts allow. **ACTIVE OPPOSITION,** because the bill is too all-inclusive; it is unclear, and puts a burden on the physician of determining insurance coverages.

Filed in accordance with the recommendation of the Reference Committee.

Public Relations

Frank Y. Watson, M.D., Chairman, Montclair

(Reference Committee "E")

The Council on Public Relations has carried on a large variety of projects of a continuing nature which are listed below, has studied a variety of new projects, and instituted those falling within the mandates of the House of Delegates and the Board of Trustees.

CONTINUING PROJECTS

a. Publication and distribution of:

(1) *Membership Newsletter*

(2) Monthly new releases on "Continuing Medical Education," "Why National Health Insurance Won't Fly,"

"Anatomy of a New Jersey Doctor," "Snow Shoveling for the Over 35 Crowd," and various other subjects ranging from National Health Insurance to Professional Liability.

b. Preparation and publication of special news releases and publicity as required from time to time in furtherance of the Society's business interest and activities, including:

(1) The Eye Health Screening Program

(2) The Annual Meeting

(3) Child Safety Week

(4) Selected official programs and activities

(5) Professional Liability—through newspaper articles explaining MSNJ's position on professional liability and the problems that are being reflected on patient care.

(6) Legislative Meetings—between MSNJ representatives and legislators regarding medical and health-related matters, such as the registration and/or licensing of physicians' assistants, professional liability, cost containment, and peer review. These meetings were of particular value in promoting the above with the legislators.

(7) Updating the legislative keymen system for legislative public relation activities.

(8) JEMPAC—continued cooperation with JEMPAC in the preparation and dissemination of promotional material encouraging physicians and their spouses to become active politically.

c. Maintaining the Information Center at the Annual Meeting for the issuance of press releases regarding newsworthy items developed at the Annual Meeting.

d. The Golden Merit Award ceremony continues to be an important function in which our senior physicians who have been in practice 50 years receive special recognition. In 1979, 90 physicians were so recognized making a total of 1,180 since the awards began in 1957. Holding these programs at the Executive Offices in Lawrenceville has been received with great favor by the recipients and the physicians participating. The recipients and their families receive undivided attention from the state and county leaders during a reception prior to the formal awards ceremonies and during the luncheon that follows.

e. Encouragement of the continuance or establishment of orientation programs for new members by the component societies.

f. Encouragement of statewide emergency medical care coverage, particularly with reference to "basic concepts underlying the provision of professional medical care" as adopted by the House of Delegates and printed in the Appendix of Reference Information in the *Membership Directory*.

g. Encouragement of increased voluntary blood donations throughout the year and particularly during vacation time in the summer and over Thanksgiving and Christmas holidays.

h. Encouragement of radio broadcasts under the auspices of component medical societies, as well as from the State Society.

i. Encouragement of medical TV programs of informational value to the public.

j. Diabetes Detection Week.

k. Placement services in *The Journal* of MSNJ.

l. Coordinate efforts of the Council on Public Relations with the Ad Hoc Committee on Drug Abuse for future MSNJ involvement in drug abuse education and prevention.

MAGAZINES

In April, September and January our ads appeared in *Time, Newsweek, U.S. News & World Report, Sports Illustrated* and *New York Magazine*. Subjects covered in the magazines included "The Value of a Second Opinion," "Anatomy of a New Jersey Doctor," and "National Health Insurance."

DIRECT MAIL

Each member of the Society receives two mailings per year. In 1979 the members were mailed a four-color poster dealing with "Anatomy of a New Jersey Doctor" and "National Health Insurance."

TELEVISION

During 1979, public service announcements were aired out of New York and Philadelphia television stations including the major network affiliates. This is the only effective way to reach our New Jersey population via television. The 30-second PSA's were run out at all time periods including prime time. These PSA's included treatment of the following subjects: "The Need for Exercise," "Middle Age," "The Need for a Checkup," "Snow Shoveling."

RADIO

In an effort to fully cover the state of New Jersey via the radio waves, PSA's were mailed to ninety-five radio stations in New Jersey, Pennsylvania, New York and Delaware. We have tried to stay with the same subject matter on radio as is used in the newspapers and television. For example, snow shoveling, national health insurance and the need for check-ups were some of the topics used. Radio is more difficult to monitor than television, however, the stations are relatively cooperative particularly in the small towns. Dover Drug Abuse Council requested permission to reuse the marihuana radio tape in their high school program.

TOMA

There is interest on the part of Toma in doing a television spot for us concerning the dangers of drugs for teenagers. This will be taped for TV release in the near future.

RODEO

Jim Myers who made the rodeo TV spot dealing with the need for exercise, has won the world's championship for bull riding. MSNJ received caption credit for the use of our tape to introduce Jim Myers on National Network (CBS).

NEW YORK TIMES

The New York Times has given us a very good standby ad rate which should help get a great deal of coverage at good cost efficiency. The one drawback is that we would not be able to control timing. We would give them the ad and wait till they could fit it in.

TV 17

TV 17 in Philadelphia agreed to give us a half hour free of charge for use as a public service. They will replay the program six times during the week. Doctors Joseph A. Riggs and Ralph A. Skowron have agreed to appear on the program and discuss "Second Opinions and Physician's Qualifications." This was taped on February 22, 1980, for immediate release through the forum segment of TV 17. This program has 60 cable station releases throughout Maryland, Delaware, New York and Connecticut in addition to the regular release through TV 17.

DRUG ABUSE

The Council on Public Relations in cooperation with the Ad Hoc Committee on Alcohol and Drug Abuse and the Department of Health arranged to mail a brochure on drug abuse to the membership.

MEMBERSHIP PROMOTION

A brochure was prepared that outlines what membership does for the doctor and the professional community. This was offered to the county societies.

DR. TODD'S CAMPAIGN FOR AMA TRUSTEE

All promotional material is being prepared by the Council on Public Relations for Doctor Todd's campaign for AMA Trustee.

Cornerstone Mailings yielded $41,441. This program is being brought to a close and a suitable memorial plaque identifying each donor is being prepared for mounting in a suitable location in the House of Delegates room in the Executive Office Building.

The Council on Public Relations' guidelines for all advertising undertaken, whether free or paid should:

a. Improve the public image of the medical profession through information.

b. Increase physician participation in MSNJ organizational activities.

c. Improve physician attendance at county and state medical society meetings.

d. Provide health information of use to the public.

e. Promote the private practice of medicine within a free enterprise system as the best way to provide the best, the most efficient, and the most accessible health care to the most people.

Recommendations for MSNJ membership participation, support, and enhancement of the medical profession's public relations program:

a. Keep abreast of current events through *careful reading of the Newsletter, The Journal* of MSNJ, and special news releases and other communications.

b. Component society officers and executive secretaries circulate to their membership pertinent information from minutes of various meetings and other releases sent to them.

c. More active participation in Medical Society programs at all levels including political action committees in the congressional districts.

d. One hundred percent participation by component society presidents and presidents-elect in leadership workshops presented by MSNJ Board of Trustees. Invite appropriate MSNJ trustees to component medical society meetings and medical specialty society meetings to give reports on current MSNJ programs and services of interest to them.

f. Component society officers or appropriate committees hold informal meetings with local representatives of the press and with state and federal legislators to establish lines of communication and discuss current medical society programs.

Filed in accordance with the recommendation of the Reference Committee.

Resolution

#9

Introduced by: **Morris County Medical Society**

Subject: **GOLDEN MERIT AWARD CEREMONY**

Referred to: **Reference Committee "E"**

Whereas, the Golden Merit Award is conferred by the Medical Society of New Jersey upon all members who have held their degree of Doctor of Medicine for fifty years; and

Whereas, historically, the bestowal of this prestigious Award has been part of the Annual Meeting of the Medical Society of New Jersey; and

Whereas, in 1979, the ceremony was held in Lawrenceville, in May, and attendance by the Officers, Fellows, Delegates, and Trustees was unimpressive; now therefore be it

RESOLVED, that the Golden Merit Award Ceremony be returned to the Annual Meeting of the Medical Society of New Jersey where it rightfully belongs; and be it further

RESOLVED, that the Medical Society of New Jersey honor these physicians as part of the 1981 Annual Meeting.

Adopted in accordance with the recommendation of the Reference Committee.

REFERENCE COMMITTEE "F"

Thomas E. Mattingly, Jr., M.D., Burlington
Chairman
L. Glenn Barkalow, M.D., Monmouth
Roger C. Laauwe, M.D., Passaic
Pascal A. Pironti, M.D., Union
Joseph A. Riggs, M.D., Camden
Elliot H. Coleman, M.D., Burlington
Alternate Member

Reports:
- Board of Trustees' Items
- Council on Medical Services and its Special Committee on Occupational Health, Workmen's Compensation, and Rehabilitation
- Committee on Medicaid
- Membership Inquiry and Complaint Committees
- Council on Mental Health
- Ad Hoc Committee on Drug and Alcohol Abuse
- Committee on Impaired Physician (Supplemental)

Board of Trustees' Items

COMMITTEE ON NEGOTIATIONS

(Reference Committee "F")

As provided in Resolution #10 (Establishment of a Committee to Assist Physicians in the Art of Negotiating), the Committee on Negotiations was organized to formulate plans as to the goals and objectives on the art of negotiating, and to review whether or not it would be advisable to establish local panels in each judicial district.

The Committee considered the following recommendations contained in the June 20, 1979 minutes of the Council on Medical Services and subsequently adopted, as amended, by the Board of Trustees:

(1) The Medical Society of New Jersey should support the right of physicians, individually, or as a group, to negotiate. (Definition of negotiation: to resolve a given problem between two or more groups of varying viewpoints in a mutually agreeable fashion.)

(2) The Medical Society of New Jersey should assist these physicians with expert help and all resources available upon the approval of the Board of Trustees.

(3) The Medical Society of New Jersey would reserve the right to agree or disagree with the results of the negotiations.

(4) In case of intra-society conflict, there should be a mechanism of mediation established to resolve differences. For example, where there is: failure of negotiations; lack of implementation of negotiated agreement; and cause for complaint arising from any negotiated issue by any group in the Society.

The Committee on Negotiations was in accord with the recommendations.

The following Policy Guidelines and Procedures for Negotiations were developed by the Committee and subsequently adopted, as amended, by the Board of Trustees:

1. **Definition of "Negotiations"**

For Society purposes, negotiations is defined as a formal meeting between specifically appointed Society officials and the official representatives of government, labor, an association, an industry, company or an organized group of individuals, the purpose of the meeting being to seek to resolve favorably a matter of significant importance to the Society.

Determination of whether the matter is of "significant importance" and subject to formal negotiations shall be made by the House of Delegates, the Board of Trustees, or the Executive Committee.

Specifically excluded from the definition of negotiations are all legislative matters, for which the Council on Legislation has authority to determine interim policy and to seek the best solutions.

2. **Areas of Negotiation**

It is expected that most negotiation efforts will occur in the areas of governmental regulatory programs and socioeconomics. Examples are proposed of operational governmental programs which interfere in the physician/patient relationship, burden physicians through increased regulatory procedures, limit physician activity, expand the inappropriate activity of nonprofessionals, or penalize physicians collectively through the imposition of unfair reimbursement programs. In the area of socioeconomics, these same examples would apply to the policies and programs of insurance companies and plan administrators.

The need for formal negotiations may also occur in the relationships which physicians have with hospitals and extended care facilities.

Negotiation efforts may also be needed in the areas of medical education, public relations, and with health professionals such as pharmacists, nurses, and others.

3. **Source of Board of Trustees' Authority to Conduct Negotiations**

The Board of Trustees shall be responsible for the Society's overall negotiations' program, providing for the selection, training, and direction of negotiators, and, when necessary, providing emergency policy guidance required by the negotiators.

4. **Principles to Guide Negotiators**

a. No individual Society member, Society component, group of members, staff, or legal counsel shall initiate any formal negotiation effort on behalf of the Society without the prior approval of the House of Delegates or the Board of Trustees. In the event that the need for action precludes presentation of the issue to the House of Delegates or the Board of Trustees, approval to negotiate may be granted by the Executive Committee (whose members are the President, President-Elect, First Vice-President, Second Vice-President, Immediate Past President, and Chairman of the Board of Trustees). Actions of the Executive Committee to grant

authority shall be reported immediately to the full Board of Trustees for approval. Actions of the Board of Trustees shall be reported to the House of Delegates at each regular session. Any subsequent disapproval by the Board of Trustees or House of Delegates shall suspend that negotiation effort.

b. The formal negotiation program shall not include activities to assist an individual Society member to resolve a dispute with a third party. Individual members will continue to be served in this regard by councils, committees, and staff of the Society. However, when it is apparent that a number of Society members are, or may be, experiencing the same difficulty with a third party, then this dispute may be subject to formal negotiations.

c. Negotiators shall be guided by a set of specific principles developed for the issue being negotiated. These principals shall define:

(1) The Society's policy on the issue
(2) The specific points to be negotiated
(3) The desired results
(4) The limits beyond which negotiations may not extend
(5) Reporting procedures to be followed subsequent to each negotiation effort

These principles will be developed prior to any negotiation effort by the House of Delegates, the Board of Trustees, or the Executive Committee.

d. Guided by these principles, negotiators shall have the authority to commit the Society to a certain course of action.

5. **Role of the President**

The President shall oversee all negotiations efforts. He shall:

a. Receive all negotiation requests offered by boards, councils, committees, members, staff, or legal counsel.

b. Determine whether existent Society policy supports or precludes the proposed negotiation effort. In the absence of needed Society policy, the President shall secure policy determination from the House of Delegates, Board of Trustees, or Executive Committee, whichever is indicated.

c. Request the approval of the House of Delegates, Board of Trustees, or Executive Committee to proceed with negotiations.

d. Appoint the negotiators (subject to the procedures outlined in 6 below).

e. Secure from a policy body the necessary specific principles needed to guide the negotiators.

f. Arrange the negotiation meeting.

g. Receive reports and report progress to the appropriate Society policy group.

6. **Qualifications and Appointment of Negotiators**

a. Negotiators shall be selected on the basis of: (1) their knowledge of the field or of the specific issue to be negotiated; (2) their ability to negotiate as evidenced by their formal training in negotiations and/or their proven leadership in Society affairs. Executive staff and legal counsel may be selected for appointment.

The expertise of the Society's allied medical organizations may be utilized through the appointment of qualified, individual members of those organizations.

b. The President may appoint all negotiators.

(1) In the selection process, he shall consult with the President-Elect and any other Society official considered knowledgeable in the specific negotiations area.
(2) An initial pool of negotiators shall be appointed and trained. This first group of negotiators shall be composed primarily of individuals with expertise in the socioeconomic area. These appointments shall be approved by the Board of Trustees.
(3) As negotiable issues are identified, the President shall appoint teams of negotiators selected from the pool and the negotiators shall be approved by the parties represented.
(4) Subsequently, if negotiators are needed for areas or issues not covered by the expertise of the pool, the President shall make the necessary new appointments, and notify the Board of Trustees at the earliest opportunity.

c. Appointments shall be at the discretion of the President.

7. **Reports of Findings, Agreements, or Recommendations**

Negotiators shall have the responsibility to report their findings, agreements, or recommendations to the Board of Trustees for approval. The Board of Trustees, which has the authority to make interim policy decisions, then shall report these activities to the House of Delegates for ratification.

8. **Training of Negotiators**

To assure the highest possible level of competence of Society negotiators, those appointed will be required to take formal training. The primary training program will be that conducted by the American Medical Association.

9. **Reimbursement of Negotiators**

When assigned to negotiate a specific issue, negotiators may be reimbursed.

Filed in accordance with the recommendation of the Reference Committee.

CT SCANNING EQUIPMENT

(Reference Committee "F")

Considerable thought and study were given to the development and utilization of CT scanning equipment both nationally and in New Jersey.

As a group representative of practicing physicians concerned with the health of patients and the type and quality of care that is rendered to them, the availability of CT scanning was a major concern. Therefore, the Board notified appropriate agencies that the CT unit should be regulated in exactly the same method as other types of primary imaging equipment.

Filed in accordance with the recommendation of the Reference Committee.

DIAGNOSIS RELATED GROUP PROJECT

(Reference Committee "F")

The mandatory implementation of the DRG Project as the form of hospital reimbursement effective, January 1, 1980, has caused considerable reaction within the medical community.

The Medical Society of New Jersey views the project as an experimental endeavor that has not yet produced documented results. Participation in the project should be by elective decision of the hospitals that satisfy program criteria.

The Society is well aware of the difficulties presented by this project to New Jersey hospitals, physicians, and patients. A special committee consisting of Jack W. Owen, President of the New Jersey Hospital Association, Joanne E. Finley, M.D., M.P.H., Commissioner of Health, Bruce C. Vladeck, Ph.D., Department of Health, Richard C. Reynolds, M.D., Rutgers Medical School, Senator Anthony Scardino, Donald Bezuyen, New Jersey Bell Telephone Company, and James S. Todd, M.D., has been created through the Hospital Research and Educational Trust (HRET) to provide an inde-

pendent study and to inform the public of the program.

Articles have been and will continue to be published in *The Journal* and *Membership Newsletter,* so the House of Delegates will be kept informed. All materials, pro and con, have been referred to a special advisory committee to the Commissioner of Health, which consists of members of the Society's Board of Trustees.

Filed in accordance with the recommendation of the Reference Committee.
(See Resolutions #3 (page 65) and #23-E, (page 67.)

PHYSICIAN REIMBURSEMENT FORMULA UNDER MEDICARE

(Reference Committee "F")

The Board of Trustees is mindful of the emphasis being placed on cost containment activity and the rise of physicians' fees in matched perspective against the Consumer Price Index. The Society has supported the voluntary effort and continues to do so. It is obvious, however, that physicians' fees allowed by Medicare have not kept pace with inflation.

The Board of Trustees has urged the AMA to seek a change in the physician reimbursement formula under Medicare to reflect current cost-of-living data.

The failure of Medicare payments for physicians' services to keep pace with inflation has been a concern of the AMA for many years. The AMA has pointed out the unrealistic nature of the so-called "economic index" as a limit on the rate of increase in Medicare prevailing charges and has sought remedial legislation to eliminate the index and to reduce the time-lag in recognition of changes in physicians' charges.

As yet, the AMA has been unsuccessful in achieving these changes, but it does continue to recognize their importance and to seek improvement in Medicare payment of physicians both in Congress and in discussions with Medicare officials.

Filed in accordance with the recommendation of the Reference Committee.

REGULATION AND COST CONTAINMENT

(Reference Committee "F")

New Jersey introduced a resolution at the AMA Annual Meeting calling upon the federal government to provide an honest cost assessment of its regulatory systems, and to phase out unnecessary and overlapping regulations and systems.

The House of Delegates of the AMA adopted the following substitute resolution:

RESOLVED, that the American Medical Association continue to urge the federal government to assess the impact of its regulatory systems on the costs of health care, and to eliminate overlapping and unnecessary regulations; and be it further

RESOLVED, that the Association continue its current efforts to inform the medical profession and the public of that portion of increased health care costs attributable to such regulatory systems.

Filed in accordance with the recommendation of the Reference Committee.

RESTRICTIONS ON THE ESTABLISHMENT OF SATELLITE CLINICS

(Reference Committee "F")

This resolution was not adopted by the House of Delegates last year, but was referred to the Board of Trustees. The Board, in turn, requested Legal Counsel's opinion. His report and recommendation follow:

Existing statutes at the federal and state levels require certificates of need for all health care facilities which clearly encompass satellite clinics. The same laws also apply to HMOs.

The procedure called for in the resolution ". . . seek the advice and consultation of the local county medical society . . ." before granting permission presents a rather curious concept. It seems as if the county medical society would not be involved when the Department of Health was predisposed to denying a certificate of need. Further, there is no mention about input at the HSA level which is really the control point under current law. Finally, it is to be noted that under present conditions local medical societies may indeed comment on all such applications. They simply must avail themselves of the opportunity. In order to implement the resolution, existing federal and state laws would require amendment. The New Jersey Department of Human Services fits nowhere in the extant picture and it is doubtful that they could be written into the law for any useful purpose.

Assuming the laws were amended via Resolution #23, the appropriate agencies would not be required to give any greater weight to the local medical society than they would to any other respondent. The net result is no effective change from the existing situation.

The Board accepted the report of Legal Counsel and voted not to adopt the resolution.

Filed in accordance with the recommendation of the Reference Committee.

Medical Services

Victor H. Boogdanian, M.D., Chairman, New Brunswick

(Reference Committee "F")

The Council is charged with the responsibility of studying and evaluating matters relevant to maintenance and advancement of the standards and character of medical practice in New Jersey, and the investigation of the economic and social aspects of medical care.

BOARD OF TRUSTEES REFERRAL—NEW JERSEY STATE SOCIETY OF ANESTHESIOLOGISTS

The New Jersey State Society of Anesthesiologists requested the support of the Medical Society in its attempt to rectify, through negotiations, the inequities in the area of economics experienced by anesthesiologists through the years.

The Council recommended and the Board of Trustees concurred in the following:

1. The Medical Society of New Jersey should support the right of physicians, individually, or as a group, to negotiate. (Definition of negotiation: to resolve a given problem between two or more groups of varying viewpoints in a mutually agreeable fashion).
2. The Medical Society should assist these physicians with expert help and all resources available upon the approval of the Board of Trustees.
3. The Medical Society would reserve the right to agree or disagree with the results of the negotiations.
4. In case of intra-society conflict, there should be a mechanism of mediation established to resolve differences. For example, where there is:
   a. Failure of negotiations;
   b. Lack of implementation of negotiated agreement;
   c. Cause for complaint arising from any negotiated issue by any group in the Society.

BOARD OF TRUSTEES REFERRAL—RESOLUTION #14—SEVERING RELATIONS WITH BLUE SHIELD OF NEW JERSEY

In their discussion the Council noted that since participating in Blue Shield of New Jersey is a voluntary process, and the only difference between participation and nonparticipation is the willingness to accept a lower fee for those patients with lower income, the Council on Medical Services sees no reason to encourage physicians to sever this type of relationship with Blue Shield of New Jersey. The Board of Trustees approved our recommendation that Resolution #14 not be adopted since participating in Blue Shield of New Jersey is a voluntary process.

REVIEW OF MEDICARE POLICY

The Council considered the complaints of two physicians because they were judged to be of general interest and applicable to all members of the Society. One concerned itself with the necessity of documenting the extent and level of consultation reports and coding for Medicare reimbursement. The other concerned itself with the sending of questionnaires to patients by Medicare's agent in order to question the services rendered and also including the claim form of the doctor on which the diagnosis appeared. Doctor Gardam of Prudential addressed these two subjects and was able to give satisfactory explanations to the Council as well as to the doctors involved. The Council came to the conclusion that the only realistic recourse was to attempt to influence a change in the legislation relative to Medicare reimbursement policy. This suggestion was submitted to the AMA with the request to seek modification of the present legislation and/or its interpretation of methods for implementation. The AMA Board of Trustees has taken this under advisement.

CONFLICT OF INTEREST

The Council on Medical Services has developed a policy on Conflict of Interest. The final version as amended by the Board of Trustees is as follows:

1. Cases where a majority of the Board of Trustees of the Medical Society of New Jersey or the House of Delegates feel there is a disabling conflict of interest in a physician's status, he/she:
   a. Should be asked to resign voluntarily from one or the other.
   b. Failing to do so voluntarily, he/she should be removed from a position of authority in the Medical Society of New Jersey.
   c. This shall not pertain to the House of Delegates, but is applicable to officers, members of the Board, and chairmen of major councils and committees.
2. At the beginning of all meetings of the Board of Trustees, councils, or committees of the Medical Society of New Jersey, the chairman of the group shall announce that members are encouraged to record themselves as abstaining from voting on any issue where they may have a conflict of interest. If a challenge is raised prior to taking a vote, the challenge shall be resolved by a majority of those present voting to disqualify the individual challenged. If less than a majority vote to disqualify, then the challenge is lost and the individual may vote.

   If a challenge is raised subsequent to a vote at the same meeting the challenge shall be resolved by a majority of those having voted. If they sustain the challenge, the action shall be rescinded, the individual disqualified, and a new vote taken.

   For the purpose of this statement, a "conflict of interest" arises when the impartiality of the member might reasonably be questioned, including but not limited to instances where he knows that he, individually or as a fiduciary, or his spouse, or relatives within the second degree of relationship has a financial interest in the subject matter under discussion or any other interest that could be affected by the outcome of the dicision.

   (*Note:* If all members of the given entity have the same or similar interest or position, then there is no "reasonable question" as to impartiality.)

COMMITTEE ON NEGOTIATIONS

Since the Council had been involved with the proposal of negotiations from its inception it is recommended that the policy guidelines and procedures for negotiations as presented by the Committee on Negotiations in their report dated August 15, 1979 be adopted by the Board of Trustees.

For additional information see the annual report of the Board of Trustees.

BOARD OF TRUSTEES REFERRAL—PENNSYLVANIA MEDICAL SOCIETY—STUDY OF MEDICAL STAFF BYLAWS

The Council on Medical Services reviewed the many concepts of developing "model bylaws." After full deliberation and complete discussion on this matter the Council recommended that a Committee be appointed to draft general medical staff guidelines concerning medical staff bylaws and that they periodically be reviewed and updated at the discretion of MSNJ.

ELECTIVE SURGERY SECOND OPINION (ESSOP)—STATUS REPORT

The Council has reviewed updated reports on the Elective Surgery Second Opinion Program (ESSOP) which summarizes experience through December 31, 1979. The Council will continue to review status reports.

PRE-ADMISSION TESTING OFFICE CONSULTATION (PATOC)

The system of payment of consultation fees for consultations done in the consultant's office prior to admission to the hospital was reviewed. As a pilot program over the last two years there were only 15 applications for reimbursement submitted and seven were paid. For this reason, it was judged that the Program did not have any significant impact. A sincere effort was made by the Union County Medical Society and by Blue Shield in that county. Blue Shield was not willing to go into any other county with this program. Perhaps the Program was before its time.

The Council agreed that the pilot study of the PATOC Program be discontinued.

Filed in accordance with the recommendation of the Reference Committee.

Occupational Health, Workmen's Compensation, and Rehabilitation

Maurice E. Goldman, M.D., Chairman, Linden

(Reference Committee "F")

Reorganization meeting of the Committee on Occupational Health, Workmen's Compensation, and Rehabilitation was held on Wednesday, January 23, 1980.

At this meeting, S-802, the New Jersey Workers' Compensation bill which Governor Byrne had signed a few weeks previously was discussed. It was felt that it was unfortunate that there had been no input from the Medical Society of New Jersey during the passage of the bill. Amendments, revisions and interpretations will be forthcoming and the committee feels that it should play a role in evaluating these and making recommendations.

Some members of the committee felt that uniform guidelines for establishing the degree of disability should be recommended by the Society to avoid the inequity that now occurs. It was decided to investigate guidelines further and to study the role the Society might take in recommending their use.

It is planned to study the new bill related to hearing loss at our next meeting.

Filed in accordance with the recommendation of the Reference Committee.

Medicaid

Harvey J. Shwed, M.D., Chairman, Newark

(Reference Committee "F")

The Medicaid Committee will be completing its fifth year as a permanent committee of the Medical Society of New Jersey. Its membership remains strong and a wide group of physicians, physician groups, and visitor-observers from other health professions continue to meet monthly with officials in the State who administer the Medicaid Program along with the representatives from the fiscal intermediary (Prudential). At the time of this writing the most crucial issue relates to a fee increase possibility which in our Committee's opinion is a basic sore point, discouraging active participation by physicians in the Medicaid Program. Medicaid administrators are cognizant of the fact that there has not been a fee increase since 1973 and have introduced a $5.25 million budgetary item for this fiscal year (this would be matched with $5.25 million in federal funds if the State budgetary requests were passed), however, at the time of this writing the mood in the Governor's office and in the State Legislature probably would reduce severely or once again eliminate such increases. The results of such penny-wise, pound-foolish stances are revealed in Medicaid statistics which suggest decreased participation by physicians and other private health care providers in the State. Certainly,

abetted by the difficulty of bureaucratic hassle, form completion, and other potential "headaches" of the Program, New Jersey physicians clearly are disenchanted at this stage. The Committee, however, is gearing a lobbying effort to point out to the legislators that they are rapidly creating, if not already accomplishing, another revisit "to class" medicine which the Medicaid Program had promised to eliminate.

New Progress—On the brighter side, the joint meetings between the Medicaid Committee and the Medicaid officials have begun to hammer out changes in regulations that may be more realistic for the private practice of medicine.

Time frames for specific procedures and other items will be somewhat reduced without a change in the fee structure. Concessions as to who may help a patient complete a pre-examination health form are under way. A Subcommittee, headed by Jonathan C. Gibbs, M.D., whose membership also includes: James Q. Atkinson, M.D., Lawrence Erlich, M.D., Elmer Grimes, M.D., Lorenzo W. Harris, M.D., Bernard Pekala, M.D., Murray Pine, D.O., Carl S. Ross, M.D., are working with the Medicaid officials on revising regulations, a slow and arduous procedure.

Our Committee welcomes Michael W. Spirito, M.D., urologist, now acting Medical Director of Medicaid.

Filed in accordance with the recommendation of the Reference Committee.

Membership Inquiry and Complaints

Joseph C. Lucci, Director, Medical and Insurance Affairs, Lawrenceville

(Reference Committee "F")

INQUIRIES AND COMPLAINTS MARCH 1, 1979 TO MARCH 1, 1980

MEDICARE

This Committee did not meet formally, since all complaints were resolved to the satisfaction of the physicians. A total of thirteen complaints was received. One complaint is pending.

MEDICAID

This Committee did not meet formally, since all complaints were resolved to the satisfaction of the physicians. A total of three complaints was received.

MEDICAL-SURGICAL PLAN OF NEW JERSEY

This Committee did not meet formally, since all complaints were resolved to the satisfaction of the physicians. A total of four complaints was received.

OTHER HEALTH INSURANCE CARRIERS

This Committee did not meet formally, since all complaints were resolved to the satisfaction of the physicians. A total of eight complaints was received. One complaint is pending.

Filed in accordance with the recommendation of the Reference Committee.

Mental Health

Harry H. Brunt, M.D., Chairman, Neptune

(Reference Committee "F")

The Council on Mental Health met in September and November of 1979 and January 1980. It will hold its last meeting in March of 1980.

The Council received a referral of House of Delegates Resolution #24 on the compulsive gambler. The Council and Dr. Brunt contacted the New Jersey Casino Control Commission and asked them what information they have to offer and received a letter stating that:

Very little documentation has been presented to the New Jersey Casino Control Commission concerning the problems of the compulsive gambler. They recognize that the problem exists but is one which is not related only to casino gambling. It is their understanding that the State Health Department recognizes the plight of the compulsive gambler as a medical problem which must be treated similarly to alcohol or drug abuse.

Any State funds to help compulsive gamblers must be authorized by the State Legislature. The State's share of the casino gaming revenue may not be used for such purposes. The Public Referendum on casino gambling in the Casino Control Act of the enabling legislature mandates that these funds go into a property tax and utility bill relief.

It was suggested that the State Health Department in Trenton be contacted to see if it can be of any assistance. Dr. Brunt immediately contacted Dr. Finley at the State Health Department and no reply was received. Dr. Brunt contacted

Gamblers Anonymous and they have not replied.

In light of legalized gambling in Atlantic City and the difficulty of the Council in obtaining any concrete information, the Council recommended that the Medical Society of New Jersey support Resolution #24 regarding the treatment of the compulsive gambler. The Board referred the recommendation back to the Council for coordination with the groups mentioned in the resolution.

The Council also remains concerned over the warehousing of former mental patients in ghetto-like environments.

The Council has had an ongoing discussion of the confidentiality of patients' records and the increased access to patients' records. The Board of Trustees will receive draft rules (Dept. of Human Services) in the very near future.

The new Federal Court decision on committed patient's consent for the administration of drugs has caused concern to psychiatrists nationwide. This decision (Rennie), while affecting mainly the state hospitals, certainly handicaps the right to treatment that patients deserve and probably will affect other branches of medicine in the near future.

Much concern was expressed over the reorganization of treatment services for children and adolescents in the state institutions.

Filed in accordance with the recommendation of the Reference Committee.

Drug and Alcohol Abuse

Edwin A. Turner, Jr., M.D., Chairman, Upper Saddle River

(Reference Committee "F")

The Committee finds that drug and alcohol abuse is a major public health problem. This problem is present in up to one-half of all encounters between physicians and their patients.

This Committee has determined that a most profound complicating factor is the profession's failure to recognize the existence of this public health problem. Too many physicians feel that the inappropriate usage of controlled, dangerous substances is outside their area of clinical responsibility even though they wish to retain the privilege of prescribing such drugs. Therefore, the Committee recommended and the Board of Trustees approved that the Medical Society of New Jersey endorse a specific education program. This was referred to the Academy of Medicine of New Jersey for possible implementation and input from the Department of Health, Office of the Attorney General, State Board of Medical Examiners, and the Committee on Impaired Physicians. This program is intended to encourage physicians to address their responsibility to their patients, the community and themselves in regard to the problems of drug and alcohol abuse. Hopefully, all physicians will be appropriately aware of this problem and prepared to provide education and treatment resources to all of their patients.

The Committee is considering education programs to be presented in cooperation with the State Department of Education, the Department of Health and pharmaceutical companies. Doctor Turner, Mr. Richard Russo and Mr. Riley Regan (State Department of Health), are presently members of the Drug and Alcohol Education Steering Committee set up by the Department of Education of the State of New Jersey.

The Committee agreed to sponsor an exhibit at the 1980 Annual Meeting, in conjunction with the Department of Health. The exhibit will deal with alcohol, drug treatment facilities, and commonly misused drugs prescribed by physicians.

The publication "This Side Up" was studied and discussed. After review, the Committee felt that it is excellent. It was recommended by the Committee and approved by the Board of Trustees that this publication be distributed to all members of the Medical Society of New Jersey. This will be done in a joint effort with the New Jersey Department of Health. It is hoped that it will be reviewed by every physician and made available to his patient population. The purpose of this effort is to express the concern and interest of the Medical Society of New Jersey in the problems of drug and alcohol abuse which the physician and his patients encounter every day. Hopefully, the physician receiving this publication will maintain a continuing effort to keep involved personally and provide appropriate information to patients with these problems.

The Committee was informed that the Division of Alcoholism supports raising the drinking age from 18 to 19 but that it also feels that a comprehensive approach is necessary to combat the problems associated with teenage drinking. The Committee recommended and the Board of Trustees approved that the Medical Society of New Jersey support the measures of the government to raise the drinking age from 18 to 19, and to provide alcohol education, prevention and intervention programs, juvenile courts, and community treatment programs for alcoholic youth.

Filed in accordance with the recommendation of the Reference Committee.

Impaired Physicians

Arthur S. McLellan, M.D., Chairman, Summit

(Reference Committee "F")

The Impaired Physicians Committee, during the past year, has continued to refine and expand its operation.

Close to 50 referrals have been processed with a variety of interventions taken which have included: identification of problems, referral for definitive management, providing followup, and serving as an advocate.

A restructuring of the program organization has taken place with regional chairmen consisting of northern, central, and southern portions of the state.

Based on the past two-years' experience of committee activity, a proposal has been made to the Society with regard to further expansion and promotion of Committee activity in the forthcoming year.

Filed with special commendation to Doctor McLellan and the entire Committee for their work during the past year, in accordance with the recommendation of the Reference Committee.

Resolutions

#2

Introduced by: **Hudson County Medical Society**

Subject: **EXPOSE COST OF GOVERNMENTAL REGULATIONS**

Referred to: **Reference Committee "F"**

Whereas, Resolution #13 (1978 House of Delegates) directed that our public relations efforts highlight the high cost of compliance with governmental regulations; and

Whereas, little if any effort has been expended in that direction to date; now therefore be it

RESOLVED, that the House of Delegates reaffirm its instruction to the Council on Public Relations to give top priority to exposing to the public the high cost and adverse effect of governmental regulations on the cost of health care and, in particular, on the voluntary cost containment effort.

Adopted in accordance with the recommendation of the Reference Committee.

#3

Introduced by: **Hudson County Medical Society**

Subject: **~~OPPOSITION TO S-446 AND~~ DIAGNOSIS RELATED GROUPS**

Referred to: **Reference Committee "F"**

Whereas, S-446 was enacted into law with minimal appreciation of the problems entailed in its implementation; and

Whereas, DRGs represent a desperate method of overcoming some of the obstacles being encountered; and

Whereas, DRGs received conditional approval from the Medical Society of New Jersey as an "experimental" program; and

Whereas, proponents of DRGs admit numerous major problems that have not been, and in some cases cannot be, resolved; and

Whereas, full implementation may prove disastrous; now therefore be it

~~RESOLVED, that the Medical Society of New Jersey urge repeal of S-446; and be it further~~

Above "Resolved" amended by the House to read as follows:

RESOLVED, that the Medical Society of New Jersey is opposed to the concept of Diagnosis Related Groups; and be it further

RESOLVED, that the Medical Society of New Jersey advocate a moratorium on further implementation of the DRG methodology until such time as the "experimental" involvement of the present 26 participating hospitals can be evaluated.

Adopted as amended by the House. (House acts on "Resolved" sections only)

#4

Introduced by: **Hudson County Medical Society**

Subject: **OPPOSITION TO FEDERAL SUBSIDY OF HEALTH MAINTENANCE ORGANIZATIONS**

Referred to: **Reference Committee "F"**

Whereas, HMOs represent an economic threat to fee-for-service physicians as well as a threat to the quality and availability of health care; and

Whereas, governmental subsidies preclude fair competition between the two; and

Whereas, such preferential policies may ultimately act to deprive fee-for-service physicians of their livelihood; now therefore be it

RESOLVED, that the Medical Society of New Jersey petition the government to cease and desist from subsidizing HMOs, and restore fair competition.

Adopted in accordance with the recommendation of the Reference Committee.

#5

Introduced by: **Hudson County Medical Society**

Subject: **OPPOSITION TO HEALTH SYSTEM AGENCIES**

Referred to: **Reference Committee "F"**

Whereas, HSAs have had sufficient time to prove their worth and have not; and

Whereas, HSAs have had sufficient time to prove their disruptive effects and have; and

Whereas, there has been sufficient time for MSNJ to have formed a retrospective opinion; and

Whereas, there is little justification for the continued cost to taxpayers of these politically motivated and politically dominated agencies; now therefore be it

RESOLVED, that the Medical Society of New Jersey go on record as being opposed to the continuing authority of these consumer-dominated Health Systems Agencies to mandate the degree and direction of future health care.

Referred to the Board of Trustees for redrafting in appropriate form and return to the House of Delegates within one year. Recommendation of the Reference Committee had been for adoption.

#6

Introduced by: **Hudson County Medical Society**

Subject: **UPDATE PHYSICIANS' FEES FOR SERVICES TO MEDICAID PATIENTS**

Referred to: **Reference Committee "F"**

Whereas, the Medicaid program was established to provide quality medical services to the poor; and

Whereas, the stated purpose of establishing Medicaid was to get the indigent patient out of "clinic" setting and into the mainstream of medical care; and

Whereas, it was anticipated that a substantial majority of physicians in New Jersey would participate in the system; and

Whereas, the fee schedule for treating Medicaid patients is inconsistent with quality medical care; and

Whereas, the result of inadequate Medicaid fees has been that only a minority of physicians are willing to treat Medicaid patients, thus defeating the purpose of getting the poor into the mainstream of medical care and forcing them instead to find care in the more expensive and less personalized setting of emergency rooms and clinics; and

Whereas, it is reported that physicians who continue to participate in the program (many as a favor to their patients) are harassed and even abused by Medicaid investigators, resulting in further decrease in the number of physicians willing to treat Medicaid patients; now therefore be it

RESOLVED, that, in order to restore the original purpose of making quality medical care available to the poor by attracting more physicians to the program, the Medical Society of New Jersey encourage legislation or any other necessary means to make adequate funds available to the program in order to update physicians' fees for services to Medicaid patients; and be it further

RESOLVED, that the Medical Society of New Jersey petition officials of the State government and of the Medicaid program to encourage Medicaid personnel to work in harmony and cooperation with physicians rather than using tactics of harassment.

Adopted in accordance with the recommendation of the Reference Committee.

#23 (E)

Introduced by: **John Winslow, M.D., Delegate**
Essex County

Subject: **DIAGNOSIS RELATED GROUP (DRG) PROGRAM**

Referred to: **Reference Committee "F"**

Whereas, with the objective of a reduction in the cost of hospital care, a new method for hospital reimbursement known as the diagnosis related group (DRG) program has recently been imposed on New Jersey hospitals, with the initial "pilot" program for twenty-six hospitals soon being shelved and made mandatory, with extension without real trial to all hospitals, perhaps under the pressure of a need to qualify for certain federal grants; and

Whereas, it has been learned before that it is impossible to have a rule or program rescinded or significantly modified once it has been instituted by the New Jersey State Department of Health under the present administration, and, therefore, it is useless to try to upend a "fait accompli" program such as the DRG; and

Whereas, nothing but notoriety comes from trying to make total opposition to a program that would reputedly cut the costs of hospital care; and

Whereas, all physicians, but internists in particular, may well have undue pressures brought upon them from hospital administrators to conform to the system, due to the economic burden placed upon their hospitals by the new DRG program; now therefore be it

RESOLVED, that, in regard to the newly instituted DRG program for hospital reimbursement, the Medical Society of New Jersey should repeatedly and strongly emphasize through all available means that the first priority for each physician's hospitalized patient must be QUALITY MEDICAL CARE, never to be compromised nor sacrificed in order to bring so-called "success" to the DRG system nor for cost savings alone. The Board of Trustees of the Medical Society of New Jersey should publicize this principle in print, including advertisements, and in all its contacts with those groups involved in the implementation of the DRG program such as the New Jersey State Department of Health, the New Jersey Hospital Association, the Blue Plans, and the various advisory councils.

Unanimously adopted in accordance with the recommendation of the Reference Committee.

REFERENCE COMMITTEE "G"

Frank J. Malta, M.D., Ocean
Chairman
Marc J. Crilly, M.D., Bergen
George T. Hare, M.D., Camden
Jeffrey M. Solomon, M.D., Cumberland
Lawrence C. Sylvia, M.D., Monmouth
Frank A. Wolf, M.D., Warren
Alternate Member

Reports:
- **Board of Trustees' Items**
- **Committee on Chronically Ill and Aging**
- **Council on Public Health and its Special Committees on:**
  - **Cancer Control**
  - **Child Health**
  - **Conservation of Hearing and Speech**
  - **Conservation of Vision**
  - **Environmental Health**
  - **Maternal and Child Care**
- **Committee on Medical Aspects of School Sports**

Board of Trustees' Items

ENCOURAGE WITHDRAWAL OF CROP SUPPORTS FOR TOBACCO

(Reference Committee "G")

The AMA Board of Trustees, in response to a resolution introduced by New Jersey (A-79) calling for AMA opposition to continuation of governmental programs of financial subsidies to tobacco growers, recommended reaffirmation of current AMA policy on smoking.

Filed in accordance with the recommendation of the Reference Committee.

HEALTH CARE IN JAILS

(Reference Committee "G")

New Jersey is one of eight states to be considered for inclusion in an experimental program to improve medical care in correctional institutions, developed by the AMA. The Board agreed the program would be of benefit to the inmates, the State, and the Society, and directed that a communication be sent to the AMA Jail Project Committee recommending that New Jersey be included in the experimental jail study program. It is expected that New Jersey would be approved for the project in the Spring of 1980.

Filed in accordance with the recommendation of the Reference Committee.

MULTIPHASIC SCREENING PROGRAMS

(Reference Committee "G")

The State Board of Medical Examiners and the Department of Health were informed of the Society's concern regarding multiphasic screening programs conducted by community service organizations and commercial enterprises. The State Board has adopted regulations in this regard; however, it was pointed out that the Medical Society of New Jersey House of Delegates believes that even greater safeguards should be adopted to protect the public. It was requested that certain revisions to the regulations be adopted which would establish that:

a. The screening programs send test results directly to the patient, indicating any abnormal results, with instructions to the patient to contact his/her personal physician.

b. In no event should test results be sent directly to the physician.

c. Patients should also be notified that it may indeed be necessary for the attending physician to repeat abnormal tests.

In response, the State Board informed the Board that the recommendations did not appear to be in the best interest of the patient. The reasoning was that in many cases the patient is the only one to receive the test results and, when this occurs, may make his/her own analysis or judgment and neglect to visit a physician for treatment which could result in a more serious illness.

The question of the physician's legal and moral obligations when receiving results showing abnormalities from a testing center for an individual who is not a patient also was discussed. It was pointed that there is no legal responsibility if there is no physician/patient relationship, the physician has no responsibility and, therefore, there is no need for the physician to further extend his services to that individual. However, when a testing center is directed by an individual to send results to a particular physician, the assumption on the part of that individual is that a physician/patient relationship exists.

Legal Counsel also secured a response from the Deputy Attorney General assigned to the State Board of Medical Examiners clarifying the legal obligations of practitioners. The interpretation accepted by the State Board of Medical Examiners is as follows:

The obligation of a physician to contact a patient who gratuitously has directed a laboratory report to be sent to that physician applies only to patients who are currently under treatment with that physician. Clearly, there is no obligation to contact persons not current patients, particularly since it was at the former patient's own initiative that the doctor was contacted, and there is thus no direct contractual relationship between them at this time. However, the physician always retains discretion to review such a gratuitously-sent report to determine whether or not to make contact with the patient as a matter of the physician's own personal ethics.

The Board voted to accept the interpretation of the State Board of Medical Examiners.

Filed in accordance with the recommendation of the Reference Committee.

Chronically Ill and Aging

David Eckstein, M.D., Chairman, Trenton

(Reference Committee "G")

The Committee on Chronically Ill and Aging did not meet during the year 1979-1980. The Chairman has been active in aiding in the formation of the New Jersey Medical Directors Association. When this Association is well established, it is hoped that the Committee on Chronically Ill and Aging can serve as its educational arm.

Since the Committee has no formal charge or mandate, it believes its primary responsibility is to effect liaison with the following groups and has conducted itself accordingly.

1. The Division of Aging of the State of New Jersey.
2. The Gerontological Society of New Jersey.
3. The newly formed New Jersey Medical Directors Association.
4. The New Jersey Association of Health Care Facilities.
5. The New Jersey Association of Non-Profit Homes for the Aging.

Filed in accordance with the recommendation of the Reference Committee.

Public Health

Peter A. Gross, M.D., Chairman, Hackensack

(Reference Committee "G")

The Board of Trustees referred to the Council on Public Health an inquiry from the Massachusetts Medical Society, concerning a program to correct any medical laboratory test with an error rate of eight percent. The Council reviewed this referral concerning regulation of laboratories and, by mail ballot, recommended and the Board of Trustees approved not participating in the program.

The Council on Public Health has a meeting scheduled on March 19, 1980.

Filed in accordance with the recommendation of the Reference Committee.

Supplemental Report

(Reference Committee "G")

The Board of Trustees, at its meeting on May 15, 1979, referred Resolution #26—"Availability of Smallpox Vaccine"—to the Council on Public Health for implementation.

The Council noted that smallpox is now considered to he eradicated from the world and therefore there is no longer any indication for smallpox vaccination for anyone, for any reason.

It also was noted that for travel to countries which still request smallpox vaccination, a physician can note on his prescription pad that the smallpox vaccination for this person is medically contraindicated, thus eliminating the necessity of the person receiving the vaccine. The Center for Disease Control agrees with this practice.

The Council recommended that the use of smallpox vaccine be ended because of current knowledge that smallpox has been eradicated worldwide, and that this vaccine especially not be used for anyone with recurrent herpes simplex disease or any other disease. For this reason the pharmaceutical companies and local health departments need not be contacted.

In view of this, the Council recommends that nothing further be done on Resolution #26.

Filed in accordance with the recommendation of the Reference Committee.

Cancer Control

Roy T. Forsberg, M.D., Chairman, Elizabeth

(Reference Committee "G")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.

Reference Committee was concerned that the Committee failed to meet during the year and recommended that the Board of Trustees reevaluate the function and scope of the Cancer Control Committee.

Child Health

Glenn P. Lambert, M.D., Chairman, Flemington

(Reference Committee "G")

The Committee on Child Health reorganized on October 3, 1979. Its meetings during this year concerned themselves with a number of problems relating to physicians rendering care to children.

Communications were carried out with the Department of Health and Medicaid Service regarding well baby clinics, child health conferences and periodic health surveys, as well as routine care. The principal concerns were that various programs set up by these agencies did not foster relationships between private doctors and their infant and children patients. There were also communications with the New Jersey Chapter of the American Academy of Pediatrics regarding similar efforts to have the State authorities comply with the Federal guidelines in these matters.

An infant safety car seat program is making some progress through cooperation with the Academy of Pediatrics, with some receptive dialogue with the New Jersey Automobile Dealers Association.

The scoliosis screening programs, conducted under the New Jersey State Law, have concerned the Committee and we, therefore, had the nurse liaison officer of the Department of Education attend the meeting. A number of concerns of the Committee include the possibility of a non-comprehensive evaluation of a child, with all the attention focused on scoliosis screening; the expense in time and training of personnel specifically to carry out the program and, lastly, the concern about unnecessary x-rays that initially were being fostered. It was felt that the Department of Education was receptive to our input.

The Committee Chairman is acting in liaison with the Department of Health in a plan for standardized immunization record forms. The lead screening program of the Department of Health also was discussed, and will be pursued further.

Other activities of the Committee and its members involved liaison with the New Jersey Chapter of the Academy of Pediatrics, so that our activities would not run counter to theirs or end up with duplication.

Filed in accordance with the recommendation of the Reference Committee.

Conservation of Hearing and Speech

Aris M. Sophocles, M.D., Chairman, Trenton

(Reference Committee "G")

The Committee on Conservation of Hearing and Speech met on February 24, 1980, to discuss the recently passed Senate Bill 3026. This is the committee whose members for years have worked to bring about legislation to provide mandatory screening of hearing in the public schools of New Jersey. Senator Merlino received our recommendations two years ago and submitted S-3026 which was passed by both chambers and was signed by Governor Byrne this year. The Chairman and members of the committee have attended meetings with the Senate Committee on Education to meet legislative requirements such as working within the budget of the Department of Education. S-3026 will require more collaboration in preparing for the implementation of this much-sought-after legislation. Screening of hearing in our public schools will be carried out without exception and with uniformity, thanks to the committee members and the State Medical Society.

Filed in accordance with the recommendation of the Reference Committee.

Conservation of Vision

Jordan D. Burke, M.D., Chairman, Summit

(Reference Committee "G")

The 23rd Annual Eye Health Screening Program was held during the week of October 7, 1979. Ninety-one hospital centers participated in the program. The number of patients screened was 6,950, of which 3,167 had a positive test finding. The testing included visual impairment, ophthalmoscopy, external conditions, and tonometry.

Of those screened, 349 had positive tonometry tests. The New Jersey Commission for the Blind and Visually Impaired will follow up these cases and report back to the Committee.

Since its inception, this program has screened 217,202 patients.

Filed in accordance with the recommendation of the Reference Committee, with commendation for the annual Eye Health Screening Program which has resulted in early detection and treatment of eye diseases. The Reference Committee is pleased with the overall good public relations generated by this program.

Environmental Health

Philip J.G. Quigley, M.D., Chairman, Elizabeth

(Reference Committee "G")

The Committee continues its liaison with the New Jersey Department of Environmental Protection.

In January 1980 members of the Committee with members of the Council on Public Health and the Committee on Cancer Control met with the Department of Environmental Protection, Division of Environmental Quality. The Department staff made presentations of their problems and efforts in the areas of solid waste, air pollution, water pollution, radiation, pesticides and noise control. Following a suggestion made at the meeting, the members of the three Medical Society of New Jersey Committees represented are being asked about their specific areas of interest so that personal contact can be made between them and the corresponding person in the Department of Environmental Protection.

In November, 1979, the Chairperson attended a meeting with the American Medical Association, Federal Environmental Protection Agency Region II, and state agency and medical society representatives from the corresponding states including New Jersey, New York and New York City. The liaison existing between the Medical Society of New Jersey and the New Jersey Department of Environmental Protection was part of the New Jersey presentation. There were one and a half days of discussion of mutual problems, including response to emergency situations such as the New York Love Canal chemical dump.

Filed in accordance with the recommendation of the Reference Committee.

Maternal and Child Care

Peter A. Beaugard, M.D., Chairman, Teaneck

(Reference Committee "G")

The Committee on Maternal and Child Care met on October 31, 1979 and February 27, 1980 to receive and act upon reports of the various subcommittees which had met on many and repeated occasions during the year. A summary of the actions of these Subcommittees follows.

SUBCOMMITTEE ON MATERNAL MORTALITY

James P. Thompson, M.D., Chairman

The Subcommittee on Maternal Mortality reviewed 27 maternal deaths for 1978. In reviewing these reports it was determined that educational efforts this year will be directed toward scoliosis and cardiac disease in pregnancy.

SUBCOMMITTEE ON TEENAGE PREGNANCY

Nicholas J. Salerno, M.D., Chairman

New Jersey Board of Education Mandate—Family Life Education—The Subcommittee agreed with the Committee on Maternal and Child Care to express its thoughts in a letter to the State Board of Education commending them for mandating family life education, but urged concern be expressed for safeguards to be included to assure that those teaching this curriculum be fully trained, competent, and not limited to health education teachers.

Services for Teenage Pregnancies—A report was given on the survey conducted by this Subcommittee on the services available to pregnant teenagers in New Jersey hospitals. A questionnaire was sent to all hospitals to determine which hospitals are providing special teenage pregnancy clinics. Out of the 83 hospitals responding, 11 provide specialty treatment for pregnant teenagers.

Because teenagers do better in their own special clinics, with more going on to complete their education, it was felt that this Subcommittee should do something to encourage establishment of more of these clinics.

AD HOC COMMITTEE ON UNIFORM OBSTETRICAL NEONATAL FORM

Thomas A. Noone, M.D., Chairman

Maternity Record Book—The Committee reviewed the proposed new Maternity Service Record Log carefully, suggesting several changes. These changes will be incorporated into

the final version of the log. *The Maternity Record Book*, 1979 Revised Edition will be available soon.

Neonatal Record Book—A proposed draft of the record book for neonates was reviewed and the format will be similar to that of the *Maternity Record Book*. Space limitations makes it necessary to decide the relative value of the data to be collected and it was decided to circularize the proposed draft to neonatologists in the State for their comments and possible revisions.

Filed in accordance with the recommendation of the Reference Committee.

Considerable discussion in the Reference Committee concerning MSNJ's letter to the Board of Education commending the mandating of sex and family life education, a controversial issue with biological and moral aspects, elicited a recommendation, approved by the House, that the matter of sex education in the schools be referred to the Board of Trustees for reconsideration of the entire issue.

Medical Aspects of School Sports

Christine E. Haycock, M.D., Chairman, Newark

(Reference Committee "G")

This Committee, which was established in 1978, held five meetings in 1979. The functions of the committee in 1979 were as follows:

1. Efforts have been under way to establish guidelines for the pre-participation examination of the school athlete. In this regard, the committee has contacted sources throughout the United States and within the State for reference material and is in the process of examining this material.
2. To further the efforts of the above, a conference has been scheduled for April 23, 1980, at which time lectures on the pre-participation examination of the school athlete will be given, particularly for the benefit of family physicians and others who are participating in sports medicine. This meeting is opened to coaches, trainers, and others, as well as physicians.
3. Other aims and goals as established in last year's report are specifically to contact, unify and harmonize the work of trainers, coaches and physicians through their respective societies in this state.
4. It is hoped that the committee eventually will become a center point of reference for guidance consultation and trouble shooting activities referable to sports medicine for all school systems, their coaches and their trainers.

RECOMMENDATION

That the Medical Society of New Jersey adopt the following resolution supporting the establishment of the AMA Committee on the Medical Aspects of Sports as a permanent standing committee:

Whereas, the American Medical Association had a viable Committee on the Medical Aspects of Sports until it was abolished on January 1, 1977; and

Whereas, sports plays an integral part in the lives of millions of Americans; and

Whereas, an increasing number of lawsuits involving sports injuries are now pending in the courts and threaten to have a pronounced effect on the sports activities of millions of Americans and thousands of schools and organizations; and

Whereas, these cases can have only an increasing effect on the physicians who treat these patients; now therefore be it

RESOLVED, that the American Medical Association House of Delegates hereby directs the Board of Trustees to reinstate the AMA Committee on the Medical Aspects of Sports.

Approved in accordance with the recommendation of the Reference Committee.

Report filed in accordance with the recommendation of the Reference Committee.

Resolutions

#13

Introduced by: **Essex County Medical Society**

Subject: **VISUAL REQUIREMENTS FOR OPERATING A MOTOR VEHICLE**

Referred to: **Reference Committee "G"**

Whereas, visual impairment is a potential cause of driving accidents; and

Whereas, current driving standards do not address all important visual functions; and

Whereas, visual abilities vary with significant change in light; and

Whereas, drivers are required to have periodic eye tests which may affect the license of many individuals and especially the elderly; now therefore be it

RESOLVED, that the Medical Society of New Jersey endorse the position already taken by the Section on Ophthalmology at the Annual Meeting of the Medical Society in May, 1978, which voted unanimously to adopt the following visual requirements for operating a motor vehicle:

1. Minimum visual acuity of 20/50 in better eye uncorrected or with best spectacle or contact lens correction.
2. Peripheral vision should be tested.
3. No color vision test is indicated.
4. No telescopic, hemianoptic or field expanding devices are sanctioned.
5. Minimum visual field should be 140 degrees when tested with 3mm. white test object at 330mms. or equivalent; and also with
6. Limited licensure for applicants with vision of 20/50 to 20/70 in either or both eyes, but with the horizontal field of vision should not be less than 140 degrees (e.g. limited licensure only in daylight).

Adopted in accordance with the recommendation of the Reference Committee, with minor editorial change. (See 3 above)

#15

Introduced by: **Essex County Medical Society**

Subject: **CESSATION OF SLUDGE DUMPING**

Referred to: **Reference Committee "G"**

Whereas, the House of Delegates of the Medical Society of New Jersey adopted a resolution in May, 1977 which called for cessation of sludge dumping in the so-called New Jersey bight; and

Whereas, the date designated for such dumping to be phased out was 1981; and

Whereas, it was recently learned that New York is attempting to overturn this 1981 deadline; and

Whereas, sludge dumping is directly related to the pollutant condition which has disrupted and curtailed New Jersey's clamming, oystering, lobstering, and fishing industries; and

Whereas, the problem of tides of dead algae threatens New Jersey's bathing beaches and could affect the health of those who use its shores for business or recreation; and

Whereas, the present system of dumping sludge close to New Jersey's beaches has now become a public health menace; now therefore be it

RESOLVED, that the Medical Society of New Jersey reaffirm its original resolution of 1977 which called for the cessation of sludge dumping by 1981; and be it further

RESOLVED, that the Medical Society of New Jersey send copies of this resolution to designated officials of the Enviromental Protection Agency, the National Oceanic Atmospheric Administration, and the Department of Environmental Protection, as well as other concerned government officials.

Adopted in accordance with the recommendation of the Reference Committee. The Reference Committee strongly urged that the Medical Society of New Jersey take an active role in calling for the cessation of sludge dumping.

#22 (E)

Introduced by: **Union County Medical Society**

Subject: **REQUEST FOR FULL DISCLOSURE OF CHEMICAL DUMP EXPLOSION IN ELIZABETH**

Referred to: **Reference Committee "G"**

Whereas, a chemical dump explosion in the site of Elizabeth has precipitated a number of medical problems in the area; and

Whereas, there are other chemical dumps throughout the state capable at any moment of creating the same hazardous situation facing the residents of Elizabeth and eastern Union County; and

Whereas, there may be information not released to the public which might be important to physicians in order to effectively treat exposed patients; now therefore be it

RESOLVED, (1) that the Medical Society of New Jersey urge the Governor and the Department of Environmental Protection to provide full disclosure of the results of the investigation of the chemical dump explosion and fire in Elizabeth;

~~(2) that the medical profession be informed of all data elicited by the investigation of this tragedy so that we may effectively detect and treat medical problems attributable to this environmental danger; and~~

Item (2) (above) amended in accordance with the recommendation of the Reference Committee to read:

(2) that the medical profession be informed of all data at the earliest possible date at the conclusion of the investigation of this tragedy so that physicians effectively may detect and treat immediately medical problems attributable to this environmental danger; and

(3) that the appropriate authorities pursue the investigation and categorization of wastes stored in other dump sites around the state; and

(4) that corrective action to eliminate such dumps be implemented forthwith.

Adopted in accordance with the recommendation of the Reference Committee.

REFERENCE COMMITTEE "H"

Bernard Robins, M.D., Union
Chairman
David L. Broadnax, M.D., Bergen
Arthur C. Lawrence, M.D., Passaic
Charles J. Moloney, M.D., Burlington
Ralph A. Skowron, M.D., Camden
Blackwell Sawyer, M.D., Ocean
Alternate Member

Reports:
Committee on Annual Meeting
MSNJ Auxiliary Advisory Committee
Nominations for Emeritus Membership

Annual Meeting

Ralph J. Fioretti, M.D., Chairman, Rochelle Park

(Reference Committee "H")

My second term as Chairman of the Committee has been filled with as many changes as my first.

In October of 1979, we were informed that construction work in Atlantic City would not be completed in time to accommodate our 214th Annual Meeting. By a stroke of "good luck," we were able to negotiate with the Meadowlands Hilton in Secaucus as the meeting site for 1980. For the first time since the days of Haddon Hall, we will be able to schedule all meetings, social affairs, exhibits, and the activities of the Auxiliary under one roof. Our one regret is that the only dates available are over Mother's Day. If we return to the Meadowlands Hilton next year, it is hoped that we can reserve dates other than Mother's Day week-end.

The Exhibit Hall is large enough to accommodate Scientific, Informational and Technical Exhibits. Booth charges for Technical Exhibits were increased to $450 for an inside booth and $500 for a corner booth. All exhibit space has been sold. The Medical Assistants again will be responsible for the Message Center, and Prudential again will sponsor the Coffee Lounge.

Last year, the Golden Merit Award Ceremony and Reception were held in the new Society Headquarters Building. This proved to be such a success that it again will be held in Lawrenceville in late May.

"Rule 4:21 Panel Hearings—Where Are We?" will be presented to the membership on Saturday morning, May 10. The 12th Annual Spencer T. Snedecor Trauma Oration is scheduled for Saturday afternoon, May 10.

Hosts for the Inaugural Reception and Dinner to be held on Sunday evening will be the Morris County Medical Society and the Medical Society of New Jersey. Music for dancing will be supplied by Phil Bennett and his orchestra. Tickets will be available—$5 per person for the reception; $35 per person for the dinner.

The Jempac Breakfast is scheduled for 7 a.m., Monday, May 12; and the Wine and Cheese Reception will be held at 6 p.m., Monday evening.

Sixty-eight outstanding speakers will participate in 20 scientific sessions to be presented on Sunday and Monday. A majority of the scientific sessions will be cosponsored by New Jersey specialty societies and MSNJ.

Because of a continued lack of attendance, the Motion Picture Theatre and the Prayer Breakfast have been eliminated for 1980.

The advance program was mailed to the membership in late February; the daily schedule appeared in several issues of *The Journal* and the *Membership Newsletter;* and the Official Program, which will be distributed to all who register at the Annual Meeting, will contain abstracts of the scientific presentations.

In spite of the continuing complications that seem to arise each year, your Committee is confident that 1980 will be a good year for the 214th Annual Meeting.

RECOMMENDATION

That the 215th Annual Meeting of the Medical Society of New Jersey be held at the Meadowlands Hilton, Secaucus, and that the Committee negotiate with the Hilton in an effort to reserve dates other than Mother's Day week-end.

Reference Committee recommendation for rejection of the above recommendation was not adopted.

The House amended the recommendation to read:

That the 215th Annual Meeting of the Medical Society of New Jersey be held at the Meadowlands Hilton, Secaucus or at another suitable place that the Board of Trustees and the Committee on Annual Meeting agree upon, and that the Committee negotiate in an effort to reserve dates other than Mother's Day weekend.

Adopted as amended by the House.

Report filed in accordance with the recommendation of the Reference Committee.

MSNJ Auxiliary Advisory

Frederick W. Durham, M.D., Chairman, Haddonfield

(Reference Committee "H")

On September 12, 1980, an emergent meeting of this Committee was called by the Chairman. Present were a member of his Committee, the President of the Medical Society of New Jersey Auxiliary, several State Auxiliary Officers, and Vincent A. Maressa, MSNJ Executive Director. The purpose was to discuss membership and leadership problems in several of the county auxiliaries. This display of unrest in the ranks was a source of shocking concern to the Chairman. Combative strategy and persuasive programing were outlined. To date, there has been an increase in membership in several of the troubled counties; while the ominous specter of possible dissolution of one county auxiliary is extant.

As an outgrowth of that conclave, an attractive MSNJ Auxiliary membership brochure has been designed and now is being printed for mailing to the Medical Society membership with a letter urging these members to encourage their spouses to join if they do not already belong to the Auxiliary.

Geared for the general Auxiliary membership, the Fall Workshop followed a new format this year consisting of varying educational programs. Speakers leading the exciting discussions were:

Alfred A. Alessi, M.D., MSNJ President
Paul Hirsch, M.D., Clinical Assistant Professor of Orthopedic Surgery, CMDNJ-Rutgers Medical School, Piscataway
Honorable William Hamilton, Senator, 17th District
Mr. Peter Sweetland, President, New Jersey State Medical Underwriters, Inc.
Mrs. John Holdcraft, HSA 3rd Vice-president Seven County Region
Leah Z. Ziskin, M.D., M.S., Director, Office of Research and Evaluation, NJ Department of Health

A "Day in the Legislature" was held by our Auxilians in Trenton in December. Senator Walter E. Foran brought the members up-to-date on what is happening in our State Government—followed by a question and answer period.

Priority has been given to fund-raising for AMA-ERF and Medical Student Loan Fund. Special interest has been given to projects on aging, safety and immunization awareness, as well as the AMA Auxiliary "Shape Up for Life" project.

This concludes the Chairman's association with the Auxiliary after a nine-year tenure. Rewarding, educational, and delightful have been the hallmark.

Filed in accordance with the recommendation of the Reference Committee.

To increase the effectiveness and activity of the Advisory Committee, its function will be reevaluated by the Committee on Long Range Planning and Development.

Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1980 Annual Meeting have been received from the component societies. Conforming to the provisions of the Bylaws, Chapter I—Membership, Section 1—Composition (e), all nominees have been members in good standing of a component society and who by reason of age or infirmity have retired from the active practice of medicine; or members of this Society who have been disabled by reason of military service.

Atlantic County

Ellis H. Allar, M.D., Ventnor City; age 75
Leonard S. Ellenbogen, M.D., Atlantic City; age 67
Amerigo L. George, M.D., Hammonton; age 69
Samuel Goldstein, M.D., Ventnor City; age 75
Raphael A. Levin, M.D., Margate City; age 65
H. Donald Marshall, M.D., Atlantic City, age 75
Jay E. Mishler, M.D., Northfield; age 68
Julius Winston, M.D., Margate City; age 78

Bergen County

Herbert Henry Eccleston, M.D., Hackensack; age 66
William Charles Giordano, M.D., Bergenfield; age 71
Nelson Charles Policastro, M.D., Sea Girt; age 78
James Buchanan Ridley, M.D., Englewood; Age 66
Mendel Silverman, M.D., Clifton; age 71
Nehemiah Elisha Smith, M.D., Englewood; age 80
George Peter Snyder, M.D., Oradell; age 65

Burlington County

William P. Mulford, M.D., Moorestown; age 65

Camden County

Jacob Louis Drosser, M.D., Haddonfield; age 67
Harry E. Fridrich, M.D., Cherry Hill; age 69
Edgar Thomas Gibson, M.D., Newagen, ME (formerly Haddonfield); age 65
Earl Blaine Keller, Jr., M.D., Burlington; age 67
Marie Ann Kelly, M.D., Cherry Hill; age 65
Edward Frank Mazur, M.D., Cherry Hill; age 65

Essex County

Anthony R. Bombardieri, M.D., Palm Beach, FL (formerly Nutley); age 67
Orlando G. Caprio, M.D., Newark; age 67
Frederick J. Dann, M.D., Short Hills; age 66
Irving J. Gross, M.D., West Orange; age 70
David B. Hoffman, M.D., Margate, FL (formerly Livingston); age 70
Frank J. Saracino, M.D., Sarasota, FL (formerly Arlington); age 70

Gloucester County

William T. Beall, M.D., Woodbury; age 70
Donald B. Weems, Sr., M.D., Wenonah; age 77

Hudson County

Anton Cziraky, M.D., Fort Lee; age 70
Hilda C. Fliegel, M.D., Coral Spring, FL (formerly Jersey City); age 72
Mario O. Gonzalez, M.D., Secaucus; age 77
David Halperin, M.D., Harvey Cedars; age 72
Walter H. Modarelli, M.D., Leonia; age 70
Harold Sager, M.D., Freehold; age 72
Charles E. Woltmann, M.D., Hoboken; age 67

Monmouth County

George S. Stevenson, M.D., Red Bank; age 87

Morris County

Leslie Earle Arnow, M.D., Morristown; age 71
Oscar H. Cohen, M.D., Sun City, AZ (formerly Boonton); age 69
Charles H. Deichman, M.D., Hagleey Gap, Jamaica (formerly Morristown); age 76
Margaret Haslett Doyle, M.D., Morristown; age 61
George Bache Emory, Jr., M.D., Basking Ridge; age 67
Amedeo Esposito, M.D., Pompano Beach, FL (formerly Morristown); age 69
M. Eugenia Geib, M.D., Morristown; age 62
Albert H. Holland, Jr., M.D., Morristown; age 62
Edward C. Kley, M.D., Hillsboro, FL (formerly Boonton); age 64
Hugh F. Luddecke, M.D., Mendham; age 63
Alvin A. Rosenberg, M.D., Boca Raton, FL (formerly Morristown); age 71

Passaic County

John R. Gannon, M.D., Hilton Head Island, SC (formerly Passaic); age 69
Bertram Koenig, M.D., Hawthorne; age 72
Margit K. Lipschitz, M.D., Westwood; age 68
Michael Raab, M.D., Passaic; age 76
Ezra Schlossberg, M.D., Cedar Grove; age 68
Leo Schwartz, M.D., Verona; age 70
Igor Sinchugov, M.D., Clifton; age 65

Salem County

George F. Reichwein, M.D., Pennsville; age 60

Union County

Joseph J. Butenas, M.D., Elizabeth; age 74
Gerald Demarest, M.D., Wilton, CT (formerly Westfield); age 69
Sidney R. Livingston, M.D., La Jolla, CA (formerly Plainfield); age 64

Approved in accordance with the recommendation of the Reference Committee.

Supplemental Report #1

(Reference Committee "H")

The following additional nominations for election to emeritus membership have been received:

Essex County

Anthony J. Biunno, M.D., Short Hills; age 70
Harrison R. Wesson, M.D., Glen Ridge; age 75

Hunterdon County

Michael A. Colella, M.D., Flemington; age 68
Vladimir F. Ctibor, M.D., Vero Beach, FL (formerly Califon); age 76
Ray F. Farley, M.D., Annandale; age 78
Paul H. Fluck, M.D., Freeport, Bahama (formerly Lambertville); age 72
John F. Fritz, M.D., Royal Palm Beach, FL (formerly Flemington); age 74
Emil A. Mondsen, M.D., Three Bridges; age 70
Edwin V. Olmstead, M.D., Flemington; age 70
Oscar M. Race, M.D., Somerville; age 79

Approved in accordance with the recommendation of the Reference Committee.

Supplemental Report #2

(Reference Committee "H")

The following additional nominations for election to emeritus membership have been received:

Atlantic County

Francis T. Reale, M.D., Brigantine; Age 62

Middlesex County

Hyman B. Copleman, M.D., New Brunswick; Age 70
Harry E. Fidler, M.D., Hawley, PA (formerly Highland Park); Age 60
Benjamin D. Jacobson, M.D., New Brunswick; Age 71
Joseph T. Lang, M.D., Sarasota, FL (formerly South River); Age 69

Passaic County

Sandor A. Levinsohn, M.D., West Palm Beach, FL (formerly Paterson); Age 83

Union County

Walter S. Booth, M.D., Elizabeth; Age 76
Thomas F. Nevins, Jr., M.D., Cranford; Age 65

Approved in accordance with the recommendation of the Reference Committee.

Report of the Nominating Committee

Offices To Be Filled by Election—1980 Annual Meeting

Charles S. Krueger, M.D., Chairman

Office	Term	Nominee and County
President-Elect	1 year	Armando F. Goracci, M.D., Gloucester
1st Vice-President	1 year	Howard D. Slobodien, M.D., Middlesex
2nd Vice-President	1 year	Alexander D. Kovacs, M.D., Union
Secretary	3 years	Arthur Bernstein, M.D., Essex
Treasurer	3 years	Rudolph C. Gering, M.D., Mercer
Trustees:		
1st District	1 year	Douglas M. Costabile, Union
1st District	3 years	Frank Y. Watson, M.D., Essex
2nd District	3 years	Ralph J. Fioretti, M.D., Bergen
5th District	3 years	Sherman Garrison, M.D., Cumberland
Judicial Councilors:		
2nd District	3 years	Robert A. Weinstein, M.D., Sussex
5th District	3 years	Ronald M. Fisher, M.D., Cumberland
AMA Delegates:		
	1 year	Myles C. Morrison, Jr., M.D., Morris
	2 years	Alfred A. Alessi, M.D., Bergen
	2 years	Frederick W. Durham, M.D., Camden
	2 years	Karl T. Franzoni, M.D., Mercer
	2 years	John S. Madara, M.D., Salem
	2 years	Henry J. Mineur, M.D., Union
AMA Alternate Delegates:		
	2 years	Palma E. Formica, M.D., Middlesex
	2 years	Charles S. Krueger, M.D., Burlington
	2 years	Carl A. Restivo, Sr., M.D., Hudson
Delegates and Alternate Delegates to Other States		
New York:		
Delegate	1 year	Albert F. Moriconi, M.D., Mercer
Alternate	1 year	F. Sterling Brown, M.D., Atlantic
Connecticut:		
Delegate	1 year	Edward M. Coe, M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic
Administrative Councils:		
Legislation:		
1st District	3 years	Anthony P. Caggiano, Jr., M.D., Essex
4th District	3 years	Irving P. Ratner, M.D., Burlington
Medical Services:		
1st District	3 years	Richard H. Sharrett, M.D., Union
2nd District	2 years	Joseph W. Fleisher, M.D., Hudson
4th District	3 years	Charles O. Tyler, M.D., Camden
Mental Health		
1st District	3 years	Alvin Friedland, M.D., Essex
2nd District	3 years	William H. Bristow, Jr., M.D., Bergen
Public Health:		
1st District	3 years	Edward M. Coe, M.D., Union
4th District	3 years	Watson E. Neiman, M.D., Burlington
Public Relations:		
1st District	3 years	Robert J. Lorello, M.D., Essex
4th District	3 years	Jesse Schulman, M.D., Ocean
Standing Committees:		
Annual Meeting	3 years	James H. Spillane, M.D., Warren
Auxiliary Advisory	3 years	George T. Hare, M.D., Camden
Finance and Budget	3 years	Charles S. Krueger, M.D., Burlington
Medical Defense and Insurance	3 years	Frank J. Malta, M.D., Ocean
Medical Education	3 years	Roberta G. Rubin, M.D., Passaic
Publication	3 years	Julio del Castilo, M.D., Mercer

ATTENDANCE

County	Delegates	Members	Total
Atlantic	5	1	6
Bergen	44	51	95
Burlington	11	6	17
Camden	18	8	26
Cape May	3	2	5
Cumberland	6	2	8
Essex	70	111	181
Gloucester	5	1	6
Hudson	23	43	66
Hunterdon	4	1	5
Mercer	26	16	42
Middlesex	24	19	43
Monmouth	23	21	44
Morris	20	20	40
Ocean	10	8	18
Passaic	26	42	68
Salem	3	3	6
Somerset	4	7	11
Sussex	3	3	6
Union	32	45	77
Warren	3	2	5
Fellows and Officers	21	—	21
	384	412	796
Physician Guests			66
Physician Exhibitors			4
Total Physician Registration			866
Auxiliary			227
Visitors			188
Exhibitors			151
Total Registration			1,432

Five-Year Comparative Registration Figures

Year	Physicians	Others	Total
1980	866	566	1,432
1979	838	728	1,566
1978	962	678	1,640
1977	1,115	1,125	2,240
1976	1,147	801	1,948

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